BLS Reimbursement Procedure

Fill out Approved Absence Form in its entirety.

Under Section III, APPROVALS, have your manager sign and date the Form.

On the Standard Voucher Form, fill out the 8 starred areas:

a) Payee ID (Last 4 of your Social Security Number)
b) Name
c) Address
d) City
e) State
f) Zip Code
g) Signature
h) Date

Upon completion of your BLS class, bring back the following to Nursing Education:

a) Approved Absence Form filled out and signed by manager
b) Standard Voucher filled out
c) Copy of your new BLS card
d) Training Center receipt of payment
e) Credit Card or Bank Statement showing the charge. Statement must also show your name, print out first page of statement if needed. All other information should be blacked out/redacted such as account number, balances, payment information, other purchases. Please note that this is a Finance/Accounts Payable requirement.

Once all your forms and paperwork are verified as complete, it will be signed by Nursing Education Director, Dr. Karen Broomes James. It will then be brought over to Accounts Payable for final processing. Payment will be in the form of either direct deposit or physical check mailed to you and may take up to 8 – 12 weeks.
REQUEST FOR AUTHORIZED ABSENCE AND FEE REIMBURSEMENT FOR CONTINUING EDUCATION PROGRAMS/PROFESSIONAL MEETINGS

NAME: ________________________ UNIT: _______________ TOUR OF DUTY: ______________________
TITLE: ________________________ SOCIAL SECURITY: ______________________

I. REQUEST FOR AUTHORIZED ABSENCE AND FEE REIMBURSEMENT FOR THE FOLLOWING EDUCATION PROGRAM TITLE OF PROGRAM: __________________________________________________________

DATE(S): ________________________ TIME: _______________ REGISTRATION FEE: ______________________
LOCATION: ______________________

II. STATEMENT ON HOW KNOWLEDGE/SKILLS GAINED FROM THIS PROGRAM WILL BE UTILIZED BY THE STAFF MEMBER IN HIS/HER WORK

_________________________________________________________________

_________________________________________________________________

III. APPROVALS

1. FOR AUTHORIZED ABSENCE: _______________ APPROVED ___________ NOT APPROVED

DIVISION SUPERVISOR ____________________________ DATE _______________
REMARKS: ______________________________________

_________________________________________________________________

_________________________________________________________________

2. FOR FEE REIMBURSEMENT: _______________ APPROVED ___________ NOT APPROVED

DIRECTOR, INSTITUTE OF CONTINUOUS LEARNING __________________________ DATE _______________
REMARKS: ______________________________________

_________________________________________________________________

_________________________________________________________________

INSTRUCTIONS: TO FACILITATE THE REQUISITION, APPROVAL, AND REIMBURSEMENT PROCESSES:
1. ATTACH WITH THIS REQUEST A COPY OF THE PROGRAM FLYER, BROCHURE OR ANNOUNCEMENT DESCRIBING THE PROGRAM.
2. SUBMIT THIS REQUEST AT LEAST TWO (2) WEEKS BEFORE THE SCHEDULED PROGRAM. NO REQUESTS SHALL BE CONSIDERED AFTER (30 DAYS).
3. AFTER PROGRAM COMPLETION, SUBMIT THE FOLLOWING DOCUMENTS TO THE INSTITUTE OF CONTINUOUS LEARNING (440 LENOX ROAD, SUITE 1J).
   • ORIGINAL CANCELLED CHECK OR ORIGINAL DUPLICATE OF MONEY ORDER.
   • COPY OF ATTENDANCE (VALIDATED FROM AN ORIGINAL BY INSTITUTE OF CONTINUOUS LEARNING).
**SEEE INSTRUCTIONS BEFORE COMPLETEING**

**STANDARD VOUCHER**

**State**
New York

**Originating Agency (limit to 30 spaces)**
SUNY Downstate Medical Center

**Org. Agency Code**
201100

**Interest Eligible (Y/N)**

**P-Contract**

<table>
<thead>
<tr>
<th>Payment Date (MM/DD/YY)</th>
<th>OSC Use Only</th>
<th>Liability Date (MM/DD/YY)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payee ID</th>
<th>Additional</th>
<th>Zip Code</th>
<th>Route</th>
<th>Payee Amount</th>
<th>MIR Date (MM/DD/YY)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payee Name (limit to 30 spaces)</th>
<th>IRS Code</th>
<th>IRS Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payee Name (limit to 30 spaces)</th>
<th>Stat. Type</th>
<th>Statistic</th>
<th>Indicator-Dept.</th>
<th>Indicator-Statewide</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address (limit to 30 spaces)</th>
<th>Refinv. No. (Limit to 20 spaces)</th>
<th>Refinv. Date (MM/DD/YY)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City (Limit to 20 spaces)</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Purchase Order No. and Date</th>
<th>Description of Material/Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If items are too numerous to be incorporated into the block below, use Form AC 93 and carry total forward.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quantity</th>
<th>Unit</th>
<th>Price</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Payee Certification**
I certify that the above bill is just, true and correct, that no part thereof has been paid except as stated and that the balance is actually due and owing, and that taxes from which the State is exempt are excluded.

Signed in Ink
Payee's Signature

Registered Nurse
Title
SUNY Downstate Health Sciences University
Name of Company

**FOR AGENCY USE ONLY**

Merchandise Received
I certify that this voucher is correct and just, and payment is approved, and the goods or services rendered or furnished are for use in the performance of the official functions and duties of this agency.

Authorized Signature in Ink
Director of Nursing Educ.

**STATE COMPTROLLER'S PRE-AUDIT**

CERTIFIED FOR PAYMENT OF TOTAL AMOUNT
Verified
Audited
Special Approval (as Required)
By

**Expenditure**

<table>
<thead>
<tr>
<th>Dept</th>
<th>Cost Center Unit</th>
<th>Var</th>
<th>Yr</th>
<th>Object</th>
<th>Accum</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Liquidation**

<table>
<thead>
<tr>
<th>Orig. Agency</th>
<th>PO/Contract</th>
<th>Line</th>
<th>F/P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Distribution:** Original to OSC with Copy to Agency/Department and Payee

□ Check if Continuation form is attached.