

Name: _____	Specialty: _____
Address: _____	Telephone: _____
City: _____	Cell/Hotline: _____
Postal Code: _____	Email: _____

Name of Course \ Conference \ Meeting: \_\_\_\_\_  
 Location: \_\_\_\_\_  
 Dates of Event: \_\_\_\_\_

**CME Credits Obtained:**  (Minimum of 3.5 credit hours per day required for each day reimbursed)  
**Certificate of Attendance Required!**

### COPIES OF RECEIPTS REQUIRED

<b>Registration Fee:</b>	\$	
<b>Transportation:</b>	\$	Mode: _____
<small>Receipts for Airfare must include destinations &amp; costs</small>		
<b>Parking Fees &amp; Taxi Fares:</b>	\$	
<b>Car Rental:</b>	\$	# of rental days: _____
<b>Mileage:</b>	\$	# of kilometers: _____
<small>Reimbursed at \$0.50 per kilometer</small>		
<b>Accommodation:</b>	\$	# of nights: _____
<small>Hotel \$300/night max   Private Residence \$80/night</small>		
<b>Meals &amp; Miscellaneous Sundry Expenses:</b>	\$	(no receipts required) # of days: _____
<small>\$95 per day</small>		
<b>Overhead Private Practice Physician:</b>	\$	# days claimed: _____
<small>\$300/day - Based on Monday to Friday practice</small>		
<b>Overhead from Practice (ER, APP, Anesthesia, etc):</b>	\$	# days claimed: _____
<small>\$180/day - Based on Monday to Friday practice</small>		

### COPIES OF RECEIPTS REQUIRED

<b>Electronic Purchases (Educational Purposes):</b>	\$	Desc: _____
<small>Max 50% of annual entitlement per year</small>		
<b>Annual Internet Provider Fees:</b>	\$	Provide Jan & Dec statements (plus any rate change month)
<b>CME Software Purchases:</b>	\$	Desc: _____
<small>Not Eligible: Word Processor, EMR Billing, etc</small>		
<b>Donation to Northern Health Library:</b>	\$	Maximum donation \$100
<b>Medical Books, Journals, CD's, etc:</b>	\$	Desc: _____

**CLAIM TOTAL:** \$ \_\_\_\_\_

**Amount Requested:** \$ \_\_\_\_\_ **Date:** \_\_\_\_\_

I hereby certify that the information provided on and with this application is truthful and accurate.  
 I understand that this claim total may need to be adjusted to comply with NCME policies:

**Physician Signature:** \_\_\_\_\_ **NCME Approval:** \_\_\_\_\_

**Allocation Available:**  
 \$ \_\_\_\_\_ (office use only)

Please return completed form with receipts to:  
 Regional Coordinator – Northern Continuing Medical Education  
**Suite 700 - 299 Victoria St, Prince George, BC, V2L 5B8**  
**Telephone (250) 565-5814 | Fax (250) 565-2251**  
[ncme@northernhealth.ca](mailto:ncme@northernhealth.ca)