



# Department of Family Medicine and Community Health

UNIVERSITY OF WISCONSIN  
SCHOOL OF MEDICINE AND PUBLIC HEALTH

## AUTHORIZATION FOR TRAVEL OR EMPLOYEE PROFESSIONAL DEVELOPMENT

\*NOTE: This form is for use by faculty, APPs, or staff

Name: \_\_\_\_\_

Date submitted: \_\_\_\_\_

Date(s) of activity: \_\_\_\_\_

No. of working days: \_\_\_\_\_

Purpose of Activity (conference title, group, etc.): \_\_\_\_\_

Location of activity: \_\_\_\_\_ \*\*international approval - start with HR

### Request for Time Away:

- Regular work time
- Leave with pay (vacation, etc)
- Leave without pay

The Department/Clinic calendar has been checked and conflicts resolved?

Yes  No

### FUNDING:

#### UWMF

Contact: Angie Stojanovich-Doyle

- CME/Professional Development
- Dept. Program Funds  
Coding: \_\_\_\_\_  
Name: \_\_\_\_\_
- Chair Discretionary Funds

#### UW

Contact: Julia Smith

[UW Policy Cheat Sheet](#)

- UW Grant Travel Funds  
Project: \_\_\_\_\_  
Name: \_\_\_\_\_
- Dept. Program Funds  
Coding: \_\_\_\_\_  
Name: \_\_\_\_\_

<i>Total Estimated Expenses</i>	
Registration Fee	\$
Lodging	\$
Meals	\$
Airfare or Mileage	\$
Other	\$
<b>Total</b>	<b>\$</b>

*\*Submit this form to your Supervisor or Project Manager who will route it to the Pool Manager (if staff CME) then to Finance\**

### APPROVAL SIGNATURES:

#### 1) SUPERVISOR APPROVAL:

- Approved as requested
- Approved as modified: \_\_\_\_\_
- Denied

Reason for denial: \_\_\_\_\_

Printed Name of Supervisor or PI/delegate \_\_\_\_\_

Signature of Supervisor or PI/delegate \_\_\_\_\_ Date \_\_\_\_\_

#### 2) POOL MANAGER'S APPROVAL (staff CME only) (Skip this step if you are a Physician or APP)

- Request granted
- Request rejected

Comment: \_\_\_\_\_

Printed Name of Pool Manager \_\_\_\_\_

Signature of Pool Manager \_\_\_\_\_ Date \_\_\_\_\_

#### 3) REVIEWED BY FINANCE

Printed Name of Financial Specialist (Angie or Julia) \_\_\_\_\_

Signature of Financial Specialist \_\_\_\_\_ Date \_\_\_\_\_

Disclaimer: Based on all info available to Finance.

NOTE: Must submit this form with related reimbursement request(s).