AREA CLINICIAN MULTI-USE SERVICE RECEIPT

For Briefings, Trainings and Trauma Response

Case Number: _____ Date:_____ Clinician Name:_____

Requesting SAC/ASAC/DTC or RAC: _____
Acknowledgement of Services Rendered Requires SAC/ASAC/RAC signature below:

_____	_____	_____
Print Name of Manager	**Signature of Manager**	**Date Signed**

***1. CLINICAL BRIEFING (trauma) SERVICES*: Type of Trauma: ☐ Operational ☐ Non-Operational**

A. Date of Briefing: _____ Briefing Location: ☐ Clinician Office ☐ DEA office ☐ Other:

B. Session #: _____ (1-4) Session Duration: _____

C. Clinical Briefing Services Provided to: ☐ Individual ☐ Group ☐ Family

D. # Supervisors Briefed: _____ # Employees Briefed: _____ # Family Members Briefed: _____ # of TTMs: _____

E. Comments: _____

***2. TRAINING SERVICES PERFORMED*:**

A. Training Title: _____

B. Date of Training: _____ Preparation Time: _____ Training Duration: _____

C. Location of Training: _____

D. # Managers Trained: _____ # Employees Trained: _____ # of TTMs:_____

***3. EXPENSE REIMBURSEMENT* (Please send receipts along with this form)**

TOTAL TRAVEL TIME (roundtrip/combined): _____ *Include totals from Form#3C if you traveled to multiple locations*

TOTAL MILES TRAVELED (roundtrip/combined): _____ *Include totals from Form#3C if you traveled to multiple locations*

Form #3C attached: ☐ Yes ☐ No

****PLEASE INCLUDE RECEIPTS and TRAVEL ITENERARIES FOR ITEMS LISTED BELOW:**

RENTAL CAR: $_____ LODGING: $_____

AIRFARE: $_____ TOLLS/PARKING: $_____ OTHER: $_____

CAB/UBER/LYFT: $_____ (Maximum tip allotted for reimbursement is 15%)

For Office Use only*: *Per Diem: $_____