AREA CLINICIAN MULTI-USE SERVICE RECEIPT

For Briefings, Trainings, Site Visits, and Trauma Response

Case Number:_____ **Date:**_____ **Clinician Name:**_____

Location Address: _____ **Division:** _____

Acknowledgment 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. **# Managers Trained:** _____ **# Employees Trained:** _____**# of TTMs:**_____

3. ***SITE VISIT PERFORMED*:**

   A. **Purpose of Visit:** _____

   B. **Date of Visit:** _____ **Duration of Stay:** _____ **Office:** _____

   C. **# Managers involved:** _____ **# Employees involved:** _____**# of TTMs:**_____

   D. **Actions Taken:**_____

   E. **Results Achieved:**_____

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

TOTAL TRAVEL TIME (roundtrip/combined): _____ **TOTAL MILES TRAVELED (roundtrip/combined):** _____

****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: $_____