ONSITE REQUEST FORM

Onsite Date: _____ **Requesting Area Clinician:** _____

Division: _____ **Office/Lab:** _____

Office Address: _____

Requesting Manager/Contact: _____ **Phone number:** _____

Type of Visit: ☐ **Training** ☐ **Management Consultation** ☐ **Trauma Response** ☐ **Site Visit**

Training Title: _____

Purpose of Visit:

_____

_____

_____

_____

_____

_____

_____

For Management Consultations only, please select requested category of service:

☐ *Addressing Performance Issues* ☐ *Promoting Positive Work Environment* ☐ *Employee Wellbeing* ☐ *Improving Teamwork and Morale*

Estimated Hours:

Training :_____ Prep Time: _____ Consultation: _____ Trauma Response:_____ Site Visit:_____

----------*TRAVEL EXPENSE ESTIMATES*----------

Estimated travel time: _____ *Estimated mileage:* _____ *Estimated flight costs: $*_____

Lodging needed? ☐ *Yes* ☐ *No* *If yes, how many nights:* _____

For Office Use Only:

Per Diem: $_____ Travel Reimbursement estimate: $_____

Prevention/Education Services CLNS $_____/hr Total Estimate: $_____

Management Services CLNS $_____/hr Total Estimate:$_____

Clinical Briefings/Trauma Response Services CLNS $_____/hr Total Estimate:$_____

Estimated combined total costs: $_____

☐ Approved ☐ Denied By: _____ Date: _____