

**Kitsap Public Health District
TRAINING/CONTINUING EDUCATION REQUEST FORM**

Employee Name: _____

Date: _____

--- THIS SECTION MUST BE COMPLETED FOR YOUR REQUEST TO BE PROCESSED ---

- Yes, I want this training/development cost pre-paid. No, I am paying/have already paid/it's free.
- Please register for me. I have registered for the training.
- Please make my travel arrangements for me. (See attached Travel Request form)
- I am making my own travel arrangements.

Training Date(s)	Title/Location (The registration form must be attached to this request.)	Hours Required

- Core Training/Program Paid Training
Charge program paid training to (include grant/contract billing code if applicable): _____
Core training does not require use of employee's CE benefit. See District Training Policy/Procedure A-22.
- CE (Continuing Education)

Employee Must Complete Before Requesting Approval <i>(Request Balance from Accounting)</i>		
CE Benefit Balance	CE Hours Available	CE Dollars Available

Total Estimated Cost of Training Employee Must Complete Before Requesting Approval				
	Estimated Expense (Employee completes)	Prog. Mgr. Approval of Excess Expense	Actual Expense (Accounting use only)	Voucher/Vendor
Registration	\$	<input type="checkbox"/>	\$	
Meals*	\$	<input type="checkbox"/> *	\$	
Lodging*	\$	<input type="checkbox"/> *	\$	
Airfare	\$	<input type="checkbox"/>	\$	
Other	\$	<input type="checkbox"/>	\$	
Total	\$ \$0.00	<input type="checkbox"/>	\$	

***Meals/lodging in excess of per diem is not allowed unless the Program Manager approves it in advance.
Per diem for this request is Lodging: \$_____ ; Meals: \$_____.**

Justification for Training: License/CE requirements Improve current job skills/meet performance objectives Other _____

Employee's Signature: _____ Date: _____

Program Manager's Signature: _____ Date: _____

For Out-of-State Travel only, also obtain Division Director's approval below:

Division Director's Signature: _____ Date: _____

Route to Purchasing after approvals have been obtained.

**KITSAP PUBLIC HEALTH DISTRICT
TRAVEL REQUEST FORM**

Employee Name: _____ Date: _____

--- THIS SECTION MUST BE COMPLETED FOR YOUR REQUEST TO BE PROCESSED ---

This travel is for:

- Training:** Training Title: _____
- Meeting/Conference** Meeting/Conf. Title: _____
- Other:** Describe: _____

Charge Travel Costs to: _____

Request for Hotel/Motel Accommodations				
Destination City/State		Hotel Per Diem		
Arrival Date		Departure Date		
Preferred Hotel/Motel Or No Preference		Number of Nights		
Request for Airline Reservation				
<i>Note: Purchasing makes all airline reservations</i>				
Date of Arrival to Destination		Preferred Arrival Time		
Date of Departure		Preferred Departure Time		
Airline Preference Frequent Flier Account		Seating Preference		
Total Estimated Cost of Travel				
<i>Employee must complete unless already completed on the Training Request Form.</i>				
	Estimated Expense (Employee completes)	Program Manager Initial to Approve Excess Expense	Actual Expense (Accounting use only)	Voucher/Vendor
Registration	\$	<input type="checkbox"/>	\$	
Meals	\$	<input type="checkbox"/>	\$	
Lodging	\$	<input type="checkbox"/>	\$	
Airfare	\$	<input type="checkbox"/>	\$	
Other	\$	<input type="checkbox"/>	\$	
Total	\$ 0.00	<input type="checkbox"/>	\$	

Employee's Signature: _____ Date: _____

Program Manager's Signature: _____ Date: _____

For Out-of-State Travel only, also obtain Division Director's approval:

Division Director's Signature: _____ Date: _____

Route to Purchasing after approvals have been obtained.

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CE BOOK REQUEST FORM
(All requests need pre-approval.)

Employee Name: _____

Date: _____

My CE balance is \$ _____ in 201__.

Book order purchases may not exceed your CE balance. Your CE funds cover all costs including shipping, handling, and sales tax.

Fill in ALL information for each book you are ordering.				
Book Title	Author	ISBN #	Vendor	Cost
How will you use the books?			Subtotal	
			Sales Tax	
			S&H	
			Total	

Employee's Signature: _____

Date: _____

Program Manager's Signature: _____

Date: _____

Division Director's Signature: _____

Date: _____

FOR ACCOUNTING USE ONLY	
Date	Voucher No.

Professional Development and/or Logistics Request

First: MI: Last: Email:

Program Program Mgr: PM Email:

I am requesting:

- Core/Program Paid Training
- Continuing Education
- Travel Only
- Required District Training
- CE Hours Only
- Other

to pay for one of the following:

Depending upon the selection here, only related portions of this form will open for the user.

- Licensure
- Books/Subscriptions
- Registration Fee for any of the following:
class, exam, conference, seminar, webinar
- Membership
- Other

If accessing your Continuing Education (CE) allowance: You must contact Accounting ([Beverly Abney](#) at x5215 or [email](#)) and enter your current CE balances here: **I have** **hours and** **dollars remaining in the current year's CE Benefit.**

LICENSURE or MEMBERSHIP:

1. Submit digital/electronic copy of registration form. (Email to [Purchasing](#) or fax to 360-475-9298; or if registration if available on-line paste the URL of registration website here:

2. (if applicable) Username: Password:

3. Your existing license/membership number (if applicable):

4. Have you already paid the fee?

- Yes – I would like to get reimbursed and will be filling out
- No I have not paid any fees.

5. Costs:

Item	Cost
Fee	\$ 0.00
Shipping/Handling	\$ 0.00
Estimated Taxes:	\$ 0.00
Total	

Name:

Request Number:

BOOKS:

Note: CE Book requests are to be approved by your Program Manager PRIOR to purchase per our [Training Policy A-22](#)).

1. Please list the books below you are requesting:

Title	Author	ISBN	Suggested Vendor	Cost
Shipping and Handling:				
Subtotal:				\$ 0.00
Estimate Taxes:	8.6%			\$ 0.00
Total Cost:				\$ 0.00

2. Have you already purchased the above books? No I have not. Yes I have purchased them.

a. If yes, [Submit Reimbursement Form](#) or I will be submitting at a later date.

3. Is the total of the purchase less than the CE Balance you received from Accounting: Yes No

a. If NO, please adjust your purchases to stay within your CE allowance.

Name:

Request Number:

REGISTRATION FEES:

- Are you registering for a: Class Exam Conference Seminar Webinar Other
- Submit a copy of any registration form (if applicable) via email to [Purchasing](#) or fax to: 360-475-9298 or for on-line registrations please copy and paste the URL of website here:

- Include the following for the registration website (if applicable):

Username: Password:

- Course Information:

Training Dates		Title	Location of Training
Start	End		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

- Estimate of Costs:

Per Diem Rates available for all locations: [“Official Government Travel Per Diem Rates”](#).

Expense Item		Cost Estimate	Actual	Voucher/Vendor <i>(for Accounting Use Only)</i>
1	Registration Fee			
2	Meals - <i>enter per diem rate:</i> \$ <input type="text"/> # Days: <input type="text"/>	\$ 0.00		
3	Lodging - <i>enter per diem rate:</i> \$ <input type="text"/> # Days: <input type="text"/>	\$ 0.00		
4	Airfare			
5	Mileage <i>(.555 /mile - Rand McNalley Mileage Estimator)</i> <input type="text"/> miles	\$ 0.00		
6	Parking Fees <i>(including ferry, airport, at destination)</i>			
7	Ground Transportation <i>(taxi, shuttles, etc.)</i>			
8	Other			
Total		\$ 0.00		

- Overage Requests:** Per our [Travel Policy A-23.2 paragraph C.8. Expenses in Excess of Per Diem](#), should any category of your request exceed the allowance specified in the [official GSA per-diem rates](#) Program Manager approval IN-ADVANCE of expenditure is required. Enter the corresponding number of the “Expense Item” and provide a brief justification of the overage.

Expense Item #	Justification for Overage	Program Manager Approval for Overage
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Name:

Request Number:

HOTEL ACCOMODATIONS:

1. Will your travel require overnight lodging: yes no
2. If yes: I will make my own reservations. Please make reservations for me.
3. Here are the details and my preferences:

a. Location where I need lodging: City State

b. Arrival Date: Departure Date: # Nights Stay:

c. Hotel Preference: No Preference I prefer: My Rewards # is:

d. Preferences (*when available*): Smoking Non-Smoking Two-Full/Queen One-King

Comments to Purchasing Agent:

Your confirmation number is:

Hotel Name:

Name:

Request Number:

AIRFARE:

1. Do you need airline reservations? yes no other

2. If yes, I prefer to:

- arrange ticketing myself; or
- have ticketing arranged for me.

3. Here are my flight details and preferences:

I need to fly into this city or airport: the state of

I would like to **depart on**: and my preferred departure time is:

I would like to **return on**: (mm/dd/yy) and my preferred return time is:

I prefer flying on airlines. My frequent flyer account # is:

My seat preference is: Aisle Middle Window No Preference

My date of birth: (mm/dd/yy) (airline ticketing procedures require).

While travelling I may be reached by phone at: (###) ###-####

An emergency contact number while I'm travelling is: (###) ###-####

Additional information/comments to Purchasing Agent:

Your Flight Confirmation Number is:

Airline:

Name:

Request Number:

Signatures:

Employee Signature

Date:



DELETE Entries



SEND to Manager



Contact Purchasing



SAVE Request



PRINT a Copy

Program Manager Use:

Justification for Continuing Education:

- Core Training Required by District
- Grant Required Training

- Performance-Based Training
- Required Membership/Licensure

- Continuing Education
- Other

Funding Source:

- Grant Funded
- Program Paid (Budgeted)

- Employee's CE
- Program Paid (Not Budgeted)

- Other
- No Cost

Program Manager

Date:



RETURN with Comments



SEND to Purchasing



CONTACT Purchasing



SAVE this Request



PRINT a Copy

This request includes travel outside the state of Washington and per [Policy A-22](#) requires Director approval:

Division Director

Date:



SEND to Purchasing



RETURN with Comments



CONTACT Purchasing



SAVE this Request



PRINT a Copy

Name:

Request Number:

Verification of Completion:

I certify that I completed this training:

Signature of Employee

Date

Additional Action(s) Required:

Accounting: _____

Supervisor: _____

Employee: _____

Human Resources: _____