

Continuing Medical Education for Rural General Practitioners Hospital Claim Form



T1

Hospital:		
Agency Code:	Quarter Ending:	Year:

Component	No. of GPs	Total Amount	DHS Contribution
CME Conference			
GP Travel			
GP Accommodation			
GP Out-of-Pocket Expenses			
Locum			
Locum Accommodation			
Locum Travel			
Total			

Total DHS Contribution: \$

Hospital Assessor:

Title:

Contact telephone number:

I certify that the above information is true and correct:

Signature: _____ Date: _____