

Continuing Medical Education for Rural General Practitioners Hospital Claim Form



T1

Agency: _____

Output: _____ Period: _____ 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: _____