UConn Health
GUEST / CANDIDATE
TRAVEL AUTHORIZATION FORM

Revised 01/2024

☐ GUEST
☐ CANDIDATE

Department: _____ **Mail Code:** _____

Guest Host: _____ **Phone:** _____

Guest Name (first, full middle, last): _____

SS#: _____ **DOB:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

☐ **US Citizen or Permanent Resident for Tax Purposes (include W-9 form with Guest TA)**

☐ **Non Resident Alien (Please attach Alien Information Collection Form)**

Business Purpose of visit to Health Center:

Guest will be traveling from: _____

Scheduled Visit Dates: **From:** _____ **To:** _____ **Confirmation #** _____

Itemized Costs

		Paid By Guest	Paid By UCHC		
Air Fare:		☐	☐		
Lodging:	$ 0.00	☐	☐		**Cost / Night: _____# of Nights**
Meals / day:	$ 0.00	☑	☐	0	**$50.00 / day w/ receipts Guest only**
Meals - Partial Day:		☑	☐		
Meal w/ Guest*: **Business meal form required*	$ 0.00	☐	☑		**total number of attendees @** $ 75.00
Rental Car:		☐	☐		
Honorarium:		☐	☑		WHEN REQUESTING HONORARIUMS, DEPARTMENTS MUST SUBMIT EITHER INDIVIDUAL OR CORPORATE SETUP PACKAGES WITH THE TRAVEL AUTHORIZATION REQUEST
Mileage:	$ 0.00	☑	☐		**# of miles @ GSA rate of:** $ 0.670
Other:		☐	☐	DESCRIPTION	
		☐	☐	DESCRIPTION	

TOTAL Paid to Guest*:	$ 0.00
TOTAL Paid FOR Guest:	$ 0.00
TOTAL COST:	**$ 0.00**

	FUND	ORG	PGM	ACCT	AMOUNT
Travel					
Honorarium					
Extra line					
Extra line					
Extra line					

BANNER ACCOUNT CODING TO BE CHARGED

Dept. Admin Signature: _____ Print Name _____ Date _____

Senior Level Approver: _____ Print Name _____ Date _____

Dir. of Finance or Designee: _____ Print Name _____ Date _____

Grants Approval (For funds beginning with 5 or 6): _____ Print Name _____ Date _____

RETURN APPROVED FORM TO: **MAIL CODE:**

PRINT **RESET**