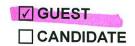


GUEST / CANDIDATE





Department: MEDICINE				Mail Code: MC1111				
Guest Host: DR. JOSEPH SMITH				Phone: (860) 679-1111				
Guest's Name: MARY HALL				ss#: 999-99-9999				
Address: 123 MAIN STRE								
City: SAN FRANCISCO		State: CA		Zip: 999	999			
✓ US Citizen or Permanent Resident for Tax Purposes								
Non Resident Alien (Please attach Alien Information Collection Form) *Fill out NRA form only if paying honorarium								
Business Purpose of visit to Health Center:								
GUEST SPEAKER FOR GRAND ROUNDS								
GOEST SPEAKER FOR GRAND ROUNDS								
Guest will be traveling from:	SAN FRANCISCO,CA							
Scheduled Visit Dates: F	rom: <u>02-12-2013</u>	то: <u>02-</u> 1	5-2013	_ Confirmat	tion # _8	88888	£	
Itemized Costs								
	Gues	aid By						
Air Fare:	\$ 450.00							
	\$ 250.00	-	\$ 125 00	Cost / Nigh	H 2	# of Nigh	ıto.	
	\$ 150.00 		3	125.00 Cost / Night: 2 # of Nights \$50.00 / day w/ receipts Guest only				
Meals - Partial Day:			3	φ50.00 / uay	w rece	eipts Guest	only	
,			10.10	a - a' ea				
Dinner w/ Guest:			10	total numbe	er of atte	endees @ _	\$ 55.00	
	\$ 100.00] [] 	DECUECTING I					
Honorarium:	\$ 0.00	OR COF	REQUESTING H	UP PACKAGES WI	EPARTMEN TH THE TRA	IS MUST SUBMI VEL AUTHORIZA	T EITHER <u>INDIVIDUAL</u> ATION REQUEST	
Mileage:	\$ 0.00		0 # of miles @ GSA rate of:\$ 0.5550					
Other:			DESCRIPTION					
TOTAL D. I.I. O. All	\$ 150.00		DESCRIPTION	ORG	PGM	ACCT	AMOUNT	
TOTAL Paid to Guest*: _ TOTAL Paid FOR Guest:	\$ 1,000.00	Travel	XXXXXX	XXXXX	XX	XXXXX	\$ 1,150.00	
TOTAL COST:	\$ 1,150.00	Honorarium Extra line						
If total paid to guest is \$3000.00 or more DO NO Instead use the Contract Information Sheet.	OT FILL OUT THIS FORM			BANNER ACC	DUNT CODIN	G TO BE CHARGE	D	
Dept. Head Signature			Print Name Date				Date	
Dir. of Finance or Designee			Print Name				D.1.	
of that to of bodigned	-ппимате				Date			
Grants Approval (For funds beginning v	Print Name				Date			
RETURN APPROVED FORM TO: MAIL CODE: MC1111								