UCONN HEALTH

Revised 06/2021

Travel and Cash Management Office to Complete:	
Batch#: _____	Check No: _____
Date: _____	Amount: $

TRAVEL ADVANCE REQUEST FORM

FORM MUST BE TYPED
Please complete sections A and B and forward to Travel and Cash Management Office, Munson Rd. MC:5105

SECTION A:

Traveler's Name: _____ Department: _____

Banner #: _____ State Employee #: _____ Mail Code: _____ Phone: _____

TA Number: _____ Destination _____ Depart Date: _____ Return Date: _____

SECTION B: Travel Advance Criterion for expenses on trips.

Out of pocket expenses range	Your Advance is
$300 - $500	$250
$501 - $1250	$500
$1251 or more	$1000

AMOUNT REQUESTED:

Note: *Please be sure NOT to include airfare or registration in the amount requested.*

SECTION C:

PROMISSORY NOTE

For value received, I _____promise to pay to the order of the University of Connecticut Health Center, on demand the sum of _____, said amount representing an advance to me.

I agree that within five (5) working days after my return, I will submit a completed Request for Reimbursement of Expenses, with the required documentation, to the General Accounting Department, MC5305. Any travel advances should be paid within ten (10) working days after completion of the trip.

I also agree, if these conditions are not met, that this amount may be deducted from my paycheck, or other monies due to me at the time, and in the manner UCONN Health's Officials deem necessary and appropriate. I also understand that future advances may be withheld if I do not comply.

SECTION D: *(To be completed when check is received)*

PRINT RESET

I hereby acknowledge and agree to the above:

Traveler's Signature:_____ Date: _____

FOR TRAVEL OFFICE USE ONLY

Travel Office Signature _____ Date: _____

☐ Credit Memo Processed Date: _____

REMEMBER TO POST DATE CREDIT MEMO FIVE (5) DAYS FROM TRAVELER RETURN DATE