Vendor # _____

Invoice # _____

INVOICE

Physician reimbursement for financial support of time spent by rural physician coordinator in the initial stages of planning for community based CME/PD events that utilize Rural Community Funds administered through VIHA.

Proposed Title of Event: _____

Learning Objectives (may require consultation with the local Medical Advisory Committee):

_____

_____

_____

Payable to (Print): _____

MSP Number: _____

Mailing Address:

_____

_____

_____

Number of hours claimed for early planning of the proposed event(s), preparation and submission of Rural Community Funds Application Form **(to be attached)**. Some early communication with proposed speakers may be included for the purpose of feasibility assessment.

_____hours @ $134.77 hour $ _____

Physician Signature: _____

Approved: _____

Executive Medical Director, Medical Staff Engagement & Development

Fax to:

Attn. Antoinette Picone
250-519-1923

***** Attach Reverted Rural Funds Application Form *****

For AP - Code: 911.41.6200001