

# Emerald Health Services Traveler Expense Reimbursement Form

RN Name \_\_\_\_\_

Facility Name \_\_\_\_\_

Contract Term: From \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

For Office Use Only: Assignment Number _____  Nurse Number _____
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Description	Period Covered	Code	Cost
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**Licencing**

State License - Renewal (State _____)	/ / to / /	LICEN	\$
State License Application Fee (State _____)	/ / to / /	LICEN	\$
Fingerprinting		LICEN	\$
Nursys, or other verification (State _____)	/ / to / /	LICEN	\$
Nursys, or other verification (State _____)	/ / to / /	LICEN	\$
Other	/ / to / /	LICEN	\$

**Certifications**

BCLS	/ / to / /	BCLS	\$
ACLS	/ / to / /	ACLS	\$
PALS	/ / to / /	PALS	\$
NRP/Fetal Heart Monitoring	/ / to / /	NRP	\$
ENPC	/ / to / /	ENPC	\$
MAB/CPI	/ / to / /	MAB	
Manuals/Books		MAT	
Other (Describe)		MISC2	\$

**Medical**

Pre-employment Physical	/ / to / /	PEP	\$
Drug Screen	/ / to / /	DS	\$
PPD	/ / to / /	PPD	\$
CXR	/ / to / /	CXR	\$
Titers	/ / to / /	TDS	
Other medical (Describe)	/ / to / /	MISC3	\$

Professional Liability Insurance (\$100 Max. Annually)	/ / to / /	INS	\$
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CEUs (Max. \$30 /Year)		CEU	\$
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**Misc.**

I.D. Photo (when required by facility)		MISC4	\$
Fax Fees		MISC4	\$
Other		MISC4	\$

<b>Total</b>	<b>\$</b>
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Include copies of documents that support costs including license, certifications, invoices, and or receipts. Copies of License and certifications must be front and back. Proof of payment is necessary for all costs. Unsupported costs will not be reimbursed.

**Fax completed form and receipts to 866-917-5055**

I certify that the information I have provided here is true and correct:

X \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Approved: \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

To be approved by EHS Management