

DIVISION OF NEPHROLOGY  
**BUSINESS TRAVEL REQUEST FORM**

Date of Request: \_\_\_\_\_

Requesting Traveler: \_\_\_\_\_

Dates of Travel (inclusive of departure and return dates): \_\_\_\_\_ to \_\_\_\_\_

Cities Being Traveled to: \_\_\_\_\_

\_\_\_\_\_

Reason(s) for Travel: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Source of Funds:

To Be Paid from a UAB Account Number: \_\_\_\_\_

To Be Paid from HSF Account Number: \_\_\_\_\_

To Be Paid Directly to the Traveler  
by a non-UAB Agency: \_\_\_\_\_

Estimated Costs:

Registration Fee: \_\_\_\_\_

Transportation: \_\_\_\_\_

Hotel & Meals: \_\_\_\_\_

Signature of Requesting Traveler: \_\_\_\_\_

Signature of Requesting Traveler's Supervisor (if needed): \_\_\_\_\_

Verification of \$ \_\_\_\_\_

Account  
Manager  
Approval:

Date: \_\_\_\_\_

**After account manager signature please forward to Lyn Hambright**

Division  
Approval:

Date: \_\_\_\_\_

Revised 01/28/19

**Note: Requests for Reimbursement MUST be completed within 60 days of the travel date.** Traveler initials confirm agreement with these submission requirements.

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