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: ______________________________________________________________________

_____________________________________________________________________________________

If attending an in-person conference, are any non-grant funds being used? Y/N __________

If so, has the UAB travel form been submitted/approved to swiley@uab.edu (faculty only) or Lyn Hambright (all other personnel/trainees)? Y/N __________

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: ________________________________

Verification of $ __________

Approved: ________________________________ Date: ________________________________

Note: Reimbursement for expenses must be completed within 60 days of the travel date.

Traveler’s initials

Revised 2/23/22