DVA REIMBURSEMENT PROGRAM
ESTIMATED BUDGET EXPENSE FOR 2017 CRIP

RESIDENCY PROGRAM NAME ____

ADDRESS____
Street City State Zip

RESIDENCY DIRECTOR'S NAME ____

PHONE NUMBER ____

EMAIL ADDRESS ____

CRIP SECTION	EAST – Section 1 JAN 12 – 14 VA Programs interview 1/12	WEST – Section 2 JAN 15 – 17 VA Programs interview 1/17	Office Use
Number of Staff (limit 2)			
Number of Nights			
Air Fare x # of staff (minimum 21 day advance purchase required)			
Transportation to/from home airport ($.54 per mile if driving)			
Home Airport Parking			
Airport Transportation to/from hotel **($140 per program max)**			
Daily Meals (maximum $70/pp/day)			
Lodging (see policy)			
FOR THOSE NOT FLYING			
Actual Round Trip Mileage & Tolls			

Total Estimated Costs: ______________________________

By submitting this budget request, I attest that we have pursued other funding sources and that there are no other funds available for our participation in the CRIP program.

RESIDENCY PROGRAM DIRECTOR ______________________________________

HOSPITAL DIRECTOR or
CHIEF OF EDUCATION ____

THIS FORM MUST BE RECEIVED BY AACPM NO LATER THAN OCTOBER 14, 2016

Completed forms can be faxed to us at 301-948-1928 or emailed to sclaffey@aacpm.org