College of Physicians & Surgeons of Alberta

Statement of Services Rendered- Expenses

Service Performed By: ***(Please Print)***

*Name: _____ Facility #: _____

Complaint #: _____

Payment Method:

Electronic Funds Transfer (EFT) ☐ Cheque ☐

Payment Made To:

☐ **Self**

☐ **Professional Corporation**

Name _____

GST # *(if applicable)* _____

☐ **Other**

Name _____

GST # *(if applicable)* _____

Mailing Address:

Address: _____

_____

City: _____

Postal Code: _____

Nature of Services Rendered:

*Committee Name *(one form per meeting)*: _____

*Date(s) of Services Rendered: _____ Location: _____

Claim for Expenses ***(receipts required)*:**

		(Accounting Use Only) Sub-account
Air Fare/ Bus	$	5760
Car (Return) _____ km	$	5760
Taxis	$	5760
Parking	$	5760
Meals	$	5520
Accommodation	$	5210
Sundry/Other (Specify)	$	5720
TOTAL EXPENSE CLAIM: ➡	$	

*Signature of Claimant: ***X*** _____

***Indicates mandatory field and must be complete to ensure prompt processing.**

Please return your completed form to:

The College of Physicians & Surgeons of Alberta by fax: 780-420-0651 or by mail:

2700 - 10020 100 ST NW, Edmonton AB T5J 0N3

The individually identifiable information on this form is collected by the CPSA under the authority of the Health Professions Act. It is used only for the purpose of payment of expenses and/or an honorarium and will not be disclosed to anyone other than the claimant or his/her legal representative. This financial form will be retained in compliance with federal government regulations and then securely disposed.