cpsa
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: Mailing Address:

☐ **Self** Address: _____
☐ **Professional Corporation**
Name _____ City: _____
GST# Postal Code: _____
(if applicable) _____
☐ **Other**
Name _____
GST#
(if applicable) _____

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:
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 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 their legal representative. This financial form will be retained in compliance with federal government regulations and then securely disposed.