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 email: accounting@cpsa.ab.ca

*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.*