



# COASTAL HORIZONS CENTER, INC.

"Promoting choices for healthier lives and safer communities"



- TRAINING**
- OUT OF AREA TRAVEL\***  
(\*outside New Hanover, Pender, & Brunswick Counties)

### PRIOR APPROVAL REQUEST FOR:

Instructions: Attach check requests as needed, and attach supporting documentation for event with this form. All receipts (travel, lodging, etc.) must be turned in to Administration upon completion of trip. The employee understands that if this training is not being required by their supervisor, and if the total cost for this training exceeds \$100.00, the employee will be required to reimburse the agency on a pro-rated basis for this training if they leave the agency within one (1) year of attending training.

Date Submitted: \_\_\_\_\_

Staff to Participate/Name(s): \_\_\_\_\_

Date(s) of Event: \_\_\_\_\_ Location of Event: \_\_\_\_\_

Event Description: \_\_\_\_\_

\$ \_\_\_\_\_ **Registration or Tuition Costs:** \$ \_\_\_\_\_ x \_\_\_\_\_ staff

\$ \_\_\_\_\_ **Transportation Plan (out of area only):**  Rental Vehicle (Cost = \$ \_\_\_\_\_ )

Agency Vehicle  Driving Own Car (Number of round trip miles \*60 or less : \_\_\_\_\_ x \$0.36 = \$ \_\_\_\_\_ ) \*

Riding w/Other  Driving Own Car (Number of round trip miles \*more than 60: \_\_\_\_\_ x \$0.22 = \$ \_\_\_\_\_ ) \*

Air Travel (Airfare = \$ \_\_\_\_\_ x \_\_\_\_\_ staff = \$ \_\_\_\_\_ )

Other: \_\_\_\_\_

\$ \_\_\_\_\_ **Lodging Plan:**  Hotel/Motel (Specify Location): \_\_\_\_\_

Cost = \_\_\_\_\_ per night per room x \_\_\_\_\_ rooms x \_\_\_\_\_ nights = \$ \_\_\_\_\_ )

Other (Specify Location & Cost): \_\_\_\_\_

\$ \_\_\_\_\_ **Meals/Per Diem Plan:**

	Breakfast	Lunch	Dinner	Totals
In State	_____ staff x _____ days x \$6.50 = \$ _____	_____ staff x _____ days x \$8.50 = \$ _____	_____ staff x _____ days x \$14.50 = \$ _____	\$ _____
Out of State	_____ staff x _____ days x \$6.50 = \$ _____	_____ staff x _____ days x \$8.50 = \$ _____	_____ staff x _____ days x \$16.50 = \$ _____	\$ _____

\$ \_\_\_\_\_ **Other Expenses Anticipated (specify):** \_\_\_\_\_

\$ \_\_\_\_\_ **Total Expenses (Estimated)** - to be charged to Program # \_\_\_\_\_

**Any deadlines or advances needed?**  No  Yes (Specify here: \_\_\_\_\_ )

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Finance Director Signature \_\_\_\_\_ Date \_\_\_\_\_

Supervisor Signature \_\_\_\_\_ Date \_\_\_\_\_

CEO/President Signature \_\_\_\_\_ Date \_\_\_\_\_

Program Director Signature \_\_\_\_\_ Date \_\_\_\_\_

[For Supervisor: Required  [Not Required

[For Administration: Approved  [Not Approved

[Form returned to employee on \_\_\_\_\_ ]  
(date)

\* Effective July 1, 2003, based on the criteria use one or the other mileage rate, not both.