YAKIMA VALLEY MEMORIAL HOSPITAL

RN EDUCATIONAL PROFESSIONAL DEVELOPMENT REQUEST

NAME _____ **DEPT #** _____

REQUEST TO ATTEND _____

_____

_____

LOCATION OF EVENT _____

DATE(S) OF EVENT _____ **DATE RETURN TO WORK** _____

ACTUAL EXPENSES - for Reimbursement for RN Dollars Only

TUITION / REGISTRATION . . . . $_____

☐ **Attached – Proof of Payment**

Employee Name: _____

Employee Mailing Address: _____

_____

_____

Reimbursement checks will be mailed to the above mailing address.

APPROVAL -

_____
DEPARTMENT HEAD

_____
RN Funds Administrator