



VIRGINIA
HEALTH CARE
FOUNDATION

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**Professional Development Assistance
Reimbursement/Report Form**

*Please e-mail this form to your program officer to receive reimbursement.
Each organization can receive up to \$650 a year for professional
development assistance.*

Name: _____

Organization: _____

Phone Number: _____ E-mail: _____

Course Title:

Location and Sponsor of Class:

Course start date: _____ Course finish date: _____

Course frequency (*i.e.*- weekly for nine weeks, once a month, two full days, etc.):

Total amount of reimbursement requested: \$ _____

Tuition fee: \$ _____

Travel expenses

Mileage (*at 56 cents/mile*) _____

Lodging (*maximum of \$75 a day*) _____

Meals (*maximum of \$30 a day*) _____

Total _____

(please attach receipts for meals and lodging)

(over)

Please answer the following questions:

1. Overall, what did you learn in this course?
2. Do you feel you can put the information to use in your organization? If so, how? If not, why not?
3. What were the strengths of the course?
4. What were the weaknesses of the course?
5. Would you recommend this course to others?
6. Would you take other courses from the sponsoring institution?