Baystate Health
Office of Continuing Education

SPEAKER EXPENSE FORM

Course Title & Date: _____

Description of Expense	Amount	Receipt
TOTAL		

Mail reimbursement to:

Name	_____
Street	_____
City, State, Zip	_____

Submit Expense Form along with <u>Original Receipts</u> to: *(name of program coordinator)*
Baystate Health
Office of Continuing Education
361 Whitney Ave
Holyoke, MA 01040
413-322-4242

Label #17 Verification that teacher or author honoraria and reimbursement are paid in compliance with provider's policies **(C8; SCS 3.8; 3.10)**