LOS ANGELES COUNTY/HARBOR-UCLA MEDICAL CENTER
MEAL REIMBURSEMENT CLAIM
(CIR/SEIU MOU AGREEMENT: ARTICLE 8, SECTION 7)

NAME: _____ **DEPARTMENT:** Anesthesiology

EMPLOYEE NUMBER: _____

UNIT CODE: *(Choose one)*
- ☐ Intern (PGY1) - **82422**
- ☑ Resident (PGY2+) - **82423**

MONTH: _____

	DATE[1]	ROTATION SITE	AMOUNT CLAIMED[2]
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
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22			
23			
24			
25			
26			
27			
28			
29			
30			
31			
		TOTAL CLAIM	**$ -**

I certify that the above claim was for meals incurred while on a rotation away from Harbor-UCLA Medical Center

[1]Maximum reimbursement is $25.00 per day
[2]Attach original receipts to support each claim

SIGNATURE **DATE**

APPROVED:

PROGRAM DIRECTOR **DATE**