C.E.R.

Continuing Education Requisition

Employee: ______________________________________ OT COTA PT PTA SLP

Years/Months of Service: _________________________ Facility ______________________

Course Title: ____

Course Sponsor: _________________________________ CEU hours: ______________________

Date/s of Course: _______________________________ (attach brochure or pertinent info)

Location of Course: ____

Itemized Expenses	Estimated Cost
Tuition	
Accommodations	
Travel (Specify Type)	
Meals	
Others	
Total Expense Requested	

Justification for Course:

____

____

Total Number of Days Off: _______
Therapy Coverage:

____

My signature below indicates that I agree to work full time with Trinity Rehab
for the term of one (1) year following this Continuing Education Event or a pro-rated repayment
of expenses will be due to Trinity Rehab upon my resignation.

_____________________________________ ____
Employee/Date Area Director/Date

_____________________________________ Approved ☐ __________ Amount
Clinical Specialist/Date

Denied ☐

Total Amount Calendar Year to Date __________

(including this CER/licenses & membership dues)