SESSIONAL CLAIM FORM

For completion by all persons authorized to claim sessional fees and payments for participation in a North Shore Divisions of Family Practice working group/meeting.

PERSONAL INFORMATION

MSP #: ____________________

Name: ____________________

Payable to: ____________________

Address: ____________________

____

City: ____________________

Province: ____________________ Postal Code: ____________________

REASON FOR CLAIM

Meeting: ____________________

Location: ____________________

____

Date: ____________________

TIME

No. of GP Hours Claimed: ______

No. of MOA Hours Claimed: ______

(Hourly GP rate: $117.69/hour)

(Hourly MOA rate: $20.00/hour)

____

CLAIMANT SIGNATURE

____

DIVISION LEAD SIGNATURE

›e submitted within one month of the meeting date.

›uver, B.C. V7L 2N5 | T: 604.765.3607 | F: 604.984.3746