ARROWHEAD EMS ASSOCIATION
REIMBURSEMENT FORM **July 2016**
-Please Complete Top Half Only-

Date Submitted: _____

Agency:			
Contact Name:			
Address		City, State	
		Zip	
Phone:		E-mail	

The following items must be included with a request for reimbursement:

Pre-Hospital Provider 2017 Arrowhead EMS Conference & Expo Attendance

☐ Arrowhead EMS Conference & Expo Attendee Name(s)_____
_____
_____

☐ Completed feedback survey below

Feedback Survey (Required)

Please provide information on how this reimbursement benefits your agency to help us assess training needs and improve future reimbursement opportunities. *(agency benefits, financial impact, patient care, retention, other)*

_____

_____

_____

Please feel free to continue reporting on the backside of this form or attach a document.

REIMBURSEMENT AMOUNT REQUESTED: $ _____ (not to exceed $250.00)

Send form and documentation to: **Arrowhead EMS Association**
4219 Enterprise Circle
Duluth, MN 55811
Fax 218-726-0073

Bottom section for AEMSA staff only

PURCHASE REQUISITION

FY 2017 Seatbelt Funds

Pre-Hospital Provider Conference & Expo Reimbursement

Mail by:	
Mailed on:	
Check #	
ED Approval	

Vendor ID #:		Date:		Due:	

Item Description	Account #	Amount
2017 AEMSA Conference & Expo Reimbursement	51914	