|  |  |  |
| --- | --- | --- |
| :wfumb_red.tif | **WORLD FEDERATION**  **FOR ULTRASOUND IN MEDICINE AND BIOLOGY**  **CENTER OF EDUCATION**  **REIMBURSEMENT REQUEST FORM**  *WFUMB Office PO Box 72718 London SW19 9HD UK – Tel: +44 775 2589099*  *E-mail: reimbursement@wfumb.org – Website: http://www.wfumb.org* | |
| **PLEASE EMAIL TO** **Lynne Rudd <lrudd@wfumb.org>** | | |
| **1. CENTER OF EXCELLENCE (COE) DETAILS****:** | | |
| COE NAME: | | LOCATION: |
| **2. COE SECRETARY/ADMINISTRATOR** | | |
| NAME: | | INSTITUTION: |
| ADDRESS: | | COUNTRY: |
| E-MAIL: | | TELEPHONE: |
| **3. REIMBURSENT YEAR:** | | |
| **4. EDUCATIONAL PROGRAMS ORGANIZED BY COE**  Describe the training program(s) of the year for which you are requesting reimbursement.  Attach extra pages as needed. | | |
| A. NAME & DESCRIPTION OF PROGRAM: | | |
|  | | |
|  | | |
|  | | |
|  | | |
| DATE OF PROGRAM: | | |
| NUMBER OF ATTENDEES: | | |
| REGISTRATION FEE PAID BY ATTENDEE: | | |
| COUNTRIES REPRESENTED: | | |
|  | | |
| B. NAME & DESCRIPTION OF PROGRAM: | | |
|  | | |
|  | | |
|  | | |
|  | | |
|  | | |
| NUMBER OF ATTENDEES: | | |
| REGISTRATION FEE PAID BY ATTENDEE: | | |
| COUNTRIES REPRESENTED: | | |
|  | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **5. ACCOUNTING OF EXPENSES**   * Include an accounting of the expenses for which you are requesting reimbursement. * Attach extra pages as needed. * Please attach a receipt for each item. **NOTE: Receipts must be included to receive reimbursement**. * If you do not submit a receipt, please offer an explanation. * Do not convert foreign currency to US$ * Honorarium are not reimbursed | | | | |
| **DATE** | **DESCRIPTION OF EXPENSE** | | Amount | Currency Code  (EURO, USD, etc.) |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | **Total** |  |  |

|  |
| --- |
| **6. PROPOSED BUDGET FOR UPCOMING YEAR FOR WFUMB FUNDS**  Include a budget of how you plan to spend the funds you are requesting. You may request up to $5,000 for administrative and lecture expenses. Attach extra pages as needed. |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **7. YEARLY REPORT TO WFUMB BOARD**  Please attach a copy of the report you submitted. | | | |
| Date Report was Submitted: | | | |
| **8. FORM OF PAYMENT**  **ISSUE CHECK**  **PAY BY WIRE TRANSFER**  Please note: payment can only be made to the scholarship recipient | | | |
| ACCOUNT HOLDER: | | | |
| IBAN: | | | |
| SWIFT/BIC code: | | | |
| NAME OF ACCOUNT HOLDER: | | | |
| BANK ACCOUNT NUMBER: | | | |
| BANK NAME: | | | |
| BANK ADDRESS: | | | |
| **TOTAL REIMBURSEMENT –**  **Up to $5000.00 (USD) annually** | | Currency in which you require reimbursement: | Conversion to US $  FOR SECRETARIAT USE ONLY |
|  |  |
| **9. FUNDING YEAR**: | | | |
| **10. OTHER / REMARKS**: | | | |
|  | | | |
|  | | | |
| I certify that these funds will be used by the Center of Excellence to provide ultrasound training programs on an annual basis and that I will submit annual reports, brochures, and other COE updates in a timely fashion. | | | |
| **DATE**: | **MANAGER/ADMINISTRATOR SIGNATURE**: | | |