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| :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: |
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| DATE OF PROGRAM: |
| NUMBER OF ATTENDEES: |
| REGISTRATION FEE PAID BY ATTENDEE: |
| COUNTRIES REPRESENTED: |
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| B. NAME & DESCRIPTION OF PROGRAM: |
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| NUMBER OF ATTENDEES: |
| REGISTRATION FEE PAID BY ATTENDEE: |
| COUNTRIES REPRESENTED: |
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| **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
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| **DATE** | **DESCRIPTION OF EXPENSE** | Amount | Currency Code(EURO, USD, etc.) |
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|  |  | **Total** |  |  |

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| **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. |
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| **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 |
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| **9. FUNDING YEAR**: |
| **10. OTHER / REMARKS**: |
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| 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**: |