



Application/Expense Form

CLERKSHIP TRAVEL PROGRAM

PERSONAL INFORMATION:

Last Name: _____ First Name: _____ Initials: _____
 Title: Dr. Mr. Ms. Mrs. Email Address: _____
 Telephone: _____ Fax: _____

MAILING ADDRESS:

Address Line 1: _____ Address Line 2: _____
 City/Province: _____ Postal Code: _____

SCHOOL INFORMATION:

Faculty of Medicine School: _____ Campus: _____
 Student No.: _____ Graduation Year: _____ Current year of study: Year 2 McMaster only
 Year 3
 Year 4
 Advanced/Extended

CLINICAL ROTATION INFORMATION:

Rotation Dates From: _____ MM/DD/YY To: _____ MM/DD/YY
 Academic Health Science Centre Name: _____ Site Address: _____
 Rotation Specialty: _____

EXPENSES	Date(s)	Amount(\$)	
(Please review Program Guidelines). Transportation during rotation NOT included.			
Personal vehicle: Kilometric rate (\$0.40/km for use) To Academic Health Science Centre only	MM/DD/YY	KM	
Personal vehicle: Kilometric rate (\$0.40/km for use) To Home School only	MM/DD/YY	KM	
Car rental: To Academic Health Science Centre only			
Car rental: To Home School only			
Gas (car rental only): To Academic Health Science Centre only			
Gas (car rental only): To Home School only			
Taxi			
Fare (airfare/bus/train) Please include all pages of detailed receipt(s). Please provide reason for any claimed change fees			
Accommodations			
TOTAL EXPENSES Max. \$1500 inc. tax			

COMMENTS

- I have included official documentation of rotation completion letter from Undergraduate Medical Education Office.
- I have include my SIN form and Banking Confirmation form.
- All electronic detailed itemized receipts provided. Please photocopy your completed expense form and receipts for your records. Please note Ontario Health (Health Force) reserves the right to follow up with vendors for further expense details if necessary.
- I consent to sharing information with other Ontario Health (Health Force) programs that support transition to residency and practice in Ontario. These programs may contact me to discuss programs and career opportunities in Ontario.

By signing below (in pen only, no digital signatures):

- I certify that the claimed expenses were incurred by me for the above stated period.
- I acknowledge Ontario Health (Health Force) sole discretion to determine if the application and supporting documentation complies with the program parameters and will be accepted by the CTP; and
- I confirm that I have not received funding for travel or accommodation expenses from another program.

Section to be filled in pen only, no digital signatures permitted.

Claimant’s Name: _____ Signature: _____ Date: _____

The Clerkship Travel Program is administered by Ontario Health (Health Force) with funding provided by the Government of Ontario. It is Ontario Health (Health Force) sole discretion to determine if the application and supporting documentation complies with the program parameters and will be accepted by the CTP.

INSTRUCTIONS FOR COMPLETING THE CLERKSHIP TRAVEL PROGRAM EXPENSE FORM

Prior to completing the expense form, please refer to the program guidelines and/or your approval letter for specific eligibility information.

For program guidelines, visit our web site by choosing the Clerkship Travel Program link at www.healthforceontario.ca/ctp. Enter expenses, explanations and electronic detailed itemized receipts as indicated. Submit one form for each authorized rotation.

EXPENSES

Electronic detailed itemized receipts must be submitted with the Clerkship Travel Program Expense form. Airfare, train and bus fare are based on economy class.

The kilometric rate for use of a personal vehicle is \$0.40/km. Rental of a compact car and gasoline (with original receipts) and single occupant accommodations will be covered. Please review program guidelines for complete expense details.

Travel expenses will be applicable to the following modes of transportation: personal vehicle, rental car, taxi, bus, train, commercial airlines on initial trip to Academic Health Science Centre and return trip to home school **ONLY**. (See Guidelines)

INQUIRIES

Any questions regarding how to complete the expense form should be directed to the Operations Coordinator at ctp@ontariohealth.ca

Please submit this form and all required documentation to: ctp@ontariohealth.ca

Notice of Collection: Ontario Health collects your personal information under the authority of the Connecting Care Act, 2019, Section 6. All information collected on this form may be used as necessary by Ontario Health for the proper administration of the government-funded Recruitment and Retention Programs, including assessing your eligibility to participate in and receive payment from these programs. The information on this form may also be used by Ontario Health and/or the Ministry of Health for the proper financial administration of these programs, and for conducting research and evaluating program parameters. If you require further information about the collection by Ontario Health, please contact ctp@ontariohealth.ca