

Professional Development Approval Request Form

Name: _____ Project Number: _____ Position/Title: _____ Date: _____

	COURSE	CONFERENCE/WORKSHOP	COMMITTEE/TRAINING
TITLE:			
DATE(S):			
LOCATION:			
COST:			
DURING WORK DAY:	(circle one) YES or NO	(circle one) YES or NO	(circle one) YES or NO
UNION WORKER/\$600 PER YEAR*			
NON-UNION WORKER/\$750 PER YEAR			
<i>Signature of Supervisor</i>			<i>Date:</i>
<i>Signature of Principal Investigator</i>			<i>Date:</i>
<i>Signature of Hektoen Administrator/Controller</i>			<i>Date:</i>

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 Please submit approval request form to Hektoen Accounting Department located at 2240 West Ogden Ave, Chicago, Illinois 60612:

Direct Telephone - (312) 768-6000

Fax Number - (312) 768-6010

*Exceptions will be made, as feasible, for employees who are covered by the union and need training to continue certifications up to a limit of \$1000.

FOR OFFICE USE ONLY:

ACCOUNT CODE: _____

PROJECT NUMBER: _____

R4 CODE: _____

cc: HR