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/$750 PER YEAR*			
NON-UNION WORKER/$750 PER YEAR			
Signature of Supervisor			*Date:*
Signature of Principal Investigator			*Date:*
Signature of Hektoen Administrator/Controller			*Date:*

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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
**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

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