



Completed only by the Clerk of the Board's Office
 Agenda Date: 11/20/12
 CBS Sign Off: CP

COUNTY OF ALAMEDA
OUT-OF-STATE TRAVEL AUTHORIZATION REQUEST

11/15

AUTHORIZATION NUMBER _____

TO: Susan S. Muranishi, County Administrator
 FROM: Agency / Department Head - Print Alex Briscoe
 SUBJECT: OUT-OF-STATE TRAVEL (OOST) AUTHORIZATION REQUEST
 DATE: October 25, 2012

Signature:

I am requesting your approval of the following OOST request prior to the event taking place.

PLEASE TYPE / PRINT LEGIBLY Family Health Services AGENCY / DEPARTMENT	Nurse Family Partnership
TRAVELER'S NAME *	JOB TITLE / CLASSIFICATION or VENDOR #
1. _____	RN II Registered Nurse
2. _____	RN II "
3. _____	RN II "
4. _____	RN II "
5. _____	RN IV "

* NOTE: The only eligible personal services contractors are those who are reimbursed travel/events as stated in his/her contractual agreement with the County. Must specify Vendor # above.

DETAILS OF TRAVEL

DATES (DURATION): From: 12 / 03 / 2012 To: 12 / 07 / 2012

POINT OF ORIGIN (City/State): Oakland, CA DESTINATION (City/State): Denver, CO

PURPOSE OF TRIP: CONFERENCE MEETING SEMINAR TRAINING OTHER

NAME OR TITLE OF EVENT (no acronyms please): Nurse Family Partnership Nursing Practice Unit II

1. AUDITOR'S MAXIMUM REIMBURSEMENT (per person): \$3,000 COST PER TRANS TICKET PER PERSON: \$: 310

TOTAL COST (Max Reimb/person x no. of travelers): \$ 15,000 COUNTY TIME-OFF ONLY

ACCOUNTING INFORMATION / FUNDING SOURCE

BUSINESS UNIT	ACCOUNT No.	FUND No.	DEPT ID No.	PROGRAM No.	PROJECT/GRANT No.
PHSVC	610211	10000	350243	37180	

2. NAME OF FUNDING SOURCE (Please Specify): California Home Visiting Program

3. AMOUNT OF FUNDING \$ 15,000 4. COUNTY COST AMOUNT (Noted on the Board Agenda) 15,000

REQUESTED BY AND RETURN FORM TO:

Leslie Brouillette, PHN 21926 10-25-12
 (PRINT NAME) (QIC) (SIGNATURE) (DATE)

PHONE NUMBER: 208-5992 TIE LINE: 25992 FAX NUMBER: 267-3270

APPROVED BY: 11/1/12
 DEPT. any (PRINT NAME) (SIGNATURE) (DATE)

CAO: 11/15/12
 (PRINT NAME) (SIGNATURE) (DATE)