

STATE OF MARYLAND
MARYLAND DEPARTMENT OF HEALTH
INDIVIDUAL REQUEST FOR OUT-OF-STATE TRAVEL

H
AUTHORIZATION
NUMBER

AGENCY NAME (I.E., BOARD OF NURSING) _____

5 - Char. PCA _____

4 - Char. AOBJ _____

_____ %

AGENCY PAYING FOR TRAVEL
(If Different From Above) _____

5 - Char.PCA _____

4 - Char. AOBJ _____

_____ %

FULL NAME OF TRAVELER _____

INDEX (LOCAL HEALTH DEPTS. ONLY) _____

DESTINATION: _____

DEPARTURE DATE _____

RETURN DATE _____

PURPOSE OF TRAVEL: _____

COMMENTS: _____

METHOD OF TRAVEL:

☐ STATE CAR

☐ PRIVATE CAR

☐ BUS

☐ TRAIN

☐ AIRPLANE

ESTIMATE OF ACTUAL COSTS:

AIRPLANE:

\$ _____

TRAIN:

\$ _____

LODGING:

\$ _____ = _____ days X \$ _____
(no.) (daily rate)

MEALS:

\$ _____

REGISTRATION FEES:

\$ _____

CAR RENTAL:

\$ _____

OTHER:

\$ _____

GRAND TOTAL:

\$ _____

FUNDS ARE AVAILABLE
IN AGENCY BUDGET:

Unit Fiscal Officer

Date

TRAVEL RECOMMENDED:

Agency Head / or Designee

Date

TRAVEL APPROVED:

Deputy Secretary / or Designee

Date

FOR OUT-OF-COUNTRY TRAVEL TO CONVENTIONS, CONFERENCES, SEMINARS, OR TRAINING, THE FOLLOWING MUST BE COMPLETED.

APPROVED: _____
SECRETARY OF BUDGET AND MANAGEMENT

Date