Olive View - UCLA Medical Center

MS 301: Travel Authorization Request (TAR)

Instructions: To be completed by the faculty member requesting travel authorization only. Please provide requested information below in appropriate detail. Requests of this nature are evaluated on a case-by-case basis. All requests must be reviewed and approved by Department Head prior to submission. For reimbursement of expenses incurred during approved travel, please complete form MS-302: Request for Reimbursement of Travel Expenditures.

Requested by:

E-mail: @dhs.lacounty.gov

Department:

Proposed Travel Dates

Start:

End:

Specify: ○ Olive View Faculty ○ Fellow ◉ Resident

Destination:

City/State:

Anticipated Travel Expenses

Registration Fees:		**Accommodations:**		**Total**
Transportation (Air):		**Meals & Entertainment:**		
Transportation (Ground):		**Miscellaneous Expenses:**		

In the space below, please provide a narrative justification to support this request. Include any information pertinent to the adjudication of this request, with specific attention to the anticipated benefit to the teaching program or the academic mission of the institution.

Please print, sign, and date this request form, and submit the completed form with any supporting materials to **Medical Administration, 2C-138**.

Signature of Request Originator: _____ **Date:** _____

Signature of Department Head: _____ **Date:** _____

UCLA Use Only

Disposition: ○ Approved ○ Denied ◉ Incomplete/Insufficient **Not to Exceed:** _____

Authorized by: _____ **Date:** _____