



# Medical Office Staff Sessional Payment Form

Name:

Reimbursement Rate:

☐ \$25 hour (to cover meeting time only)

Date	Event Name (If committee, meeting or project provide name)	Activity (e.g. preparation, presentation, attendance)	Hours	Billable Expenses (Original receipt must be attached for reimbursement)	Code (office use only)
			Total Hours:	Total Expenses:	

Make cheque payable to:\*\*

Name:	Address (street, city, province, postal code)
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Signature:	Date:	Office Use
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*\*\*If you have submitted your banking information to RDFP , we will have this information already on file. Simply sign and date the invoice.*

Submit form by fax or email to:

Richmond Division of Family Practice  
Fax: 604-484-2195  
Email: [finance@rdfp.ca](mailto:finance@rdfp.ca)

Approved By:	Date:	Office Use
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