

(FORM 02-REV 11/05)

SECTION A: EVENT IDENTIFICATION

Start Date:	
End Date:	
Location:	
Clinic Number:	
No. of Meetings:	
Lead Instructor:	

Type	Pass	Fail/Inc.	Total
Type of Clinic:			
Comments:			

SECTION B: CLINIC TRAINER INFORMATION

Instructor Title	Instructor Name	Comments (% to Be Paid of Total)
Lead Instructor:		
Asst. #1:		
Asst. #2:		
Asst. #3:		
Contact:		

SECTION C: OTHER EXPENSES (Approved by SDRI in Advances --- except for postage) - Receipts MUST be attached

Item	Amount	Reason	Who to Reimburse
TOTAL:		SDRI Approval: _____	

SECTION D: RECORD OF ALL MONIES COLLECTED

Clinic Number: _____

Date Deposited: _____

For SRA Use

SOURCE OF REVENUE	# OF ITEMS	UNIT AMOUNT	AMOUNT

ACCOUNTING FOR FUNDS COLLECTED

Source	Number	Amount
Cash		
Check		
Credit Card		
Sub-Total:		
Total:		