CONCLUSION OF REGION WORKSHOP

Region__________  Division____________________  Workshop date____________________

Length of workshop (Hrs.)not including registration, breaks or lunch______________

Please circle one:  This workshop was or was not  held in conjunction with another association.

Reminders:

• Receipts for clinician travel expenses must be submitted before reimbursement is made.

• If applying for Continuing Profession Education credit, please enclose a separate sheet listing the
  names of attendees who completed the workshop.

This form must be signed below by the clinician who conducted the workshop.

Print Clinician’s Name ________________________________________________________________

Clinician’s Signature______________________________________________________________

Date____________________________________________________________________________
As previously stipulated, the honorarium /travel reimbursement check will be written and sent directly to the Region. Please provide information listed below.

Region Chair______________________________________________________________

Name of TMEA Bank Account________________________________________________

Mailing Address:

Name_______________________________________________________________

Street Address__________________________________________________________

City_____________________________ ST____ Zip____________________

Mail to: TMEA Fax: 512. 451-9213
Attn: Administrative Director Email: kvanlandingham@tmea.org
PO Box 140465
Austin, TX 78714