SAINT MICHAEL'S MEDICAL CENTER
NEWARK, NEW JERSEY
DEPARTMENT OF NURSING

Employee Information:

Name:______________________________ **Date of Request:**______________________________

Title:____________________ **Unit:**____________________ **Status:**______________ **Shift:**______________

Last CE Program Attended & Date(s):____

Reimbursement & Days Received:____

PRECEPTOR INFORMATION:

Please complete if this CE request is a result of completion of six (6) week orientation for new staff nurse.

Employee Precepted:____________________ **Unit:**________________ **Dates:**____________________

PROGRAM INFORMATION:

Title of Program:______________________________ **Sponsoring Agency:**______________________________

Description (attach program):____

Hours:______________ **Dates:**______________________________ **CEU's**____________________

APPROVALS:

1. **MANAGERS APPROVAL** ______________________________ ____________________
   Signature **Date**

2. **DIRECTORS APPROVAL** ______________________________ ____________________
   Signature **Date**

Managers approval includes paid workshop days unless specified otherwise.

REIMBURSEMENT REQUEST:

Registration Fee:____________________ Hotel:____________________ Meals:____________________

Other:____

Total:______________________________

PNPC ACTION:

Approved:______________________________ Denied:______________________________

Amount Approved:______________________________ Dates:______________________________

Comments:____

VP, NURSING______________________________ Date:______________

Chair, PNPC:______________________________ Date:______________

Revised 4/2019