Definition: Includes consultant, part-time clinical lead/advisor, and third-party service provider engaged through a service or secondment agreement.

Purpose: This form is required to seek pre-approval to travel for CCO business purposes, in line with CCO’s Travel and Business Expense Policy for Consultants and Service Providers.

Instructions:

1. As a Consultant and/or Service Provider to CCO, fully complete Part 1 and send to your CCO contact.
2. CCO will circulate to obtain required approvals.
3. Accounts Payable will retain the full approved form, and match with the invoice when submitted in step 4.
4. Upon completion of authorized travel, the Consultant and/or Service Provider is to submit an invoice and itemized receipts, for which reimbursement of expenses is requested, directly to Accounts.Payable@cancercare.on.ca. Your invoice must contain your Purchase Order number. Travel and/or business expense reimbursements will be made in accordance with CCO’s Travel and Business Expense Policy for Consultants and Service Providers, and also in accordance with the contract the Service Provider has with CCO.

Questions: Please direct questions to finance@cancercare.on.ca.

Part 1: Consultant and/or Service Provider to complete

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| **Section A: Claimant Information** |
| Name: |       | Position:  |       |
| Organization: |        |
| Purchase Order Number: |        |
| **Section B: Travel Information** |
| Justification for Travel:  |       |
| Departure Date: |       | Return Date:  |       |
| Destination: |        |
| Please select:  |  [ ]  Travel within Canada and Continental USA [ ]  International Travel (complete Request for Approval for International Travel form |
| **Section C: Estimated Expenses - Total estimated expenses that will be incurred on behalf of CCO** |
| **Transportation** |
|  [ ]  Airfare [ ]  Train | To:       From:        | $       |
| Car Rental & Gas | To:       From:        | $       |
| Parking | To:       From:        | $       |
| Mileage # KM:       ($0.40/km)  | To:       From:        | $       |
|  [ ]  Taxi [ ]  Public Transportation | To:       From:        | $       |
| **Accommodation** |
| # of nights |       | Rate | $        | Fees and Taxes | $       | $       |
| **Total Estimated Expenses:**  | $       |
| **Comment:**       |
| **Section D: Signature of Claimant** |
| Signature: |       | Date: |       |

Part II: Cancer Care Ontario to complete

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| **CCO Cost Centre Director** |
| Name: |       |
| Signature: |       | Date: |       |
| **CCO Portfolio Vice President** |
| Name: |       |
| Signature: |       | Date: |       |
| **CCO Chief Financial Officer** |
| Name: |       |
| Signature: |       | Date: |       |

Please send fully approved form to Accounts Payable.