



MEMORANDUM

Date:

To:

Through:

From:

Subject: Request for Approval of Appropriated Funds for the Reimbursement of Expenses for Professional Credentials

Licensure/Credentialing Organization:	<input type="text"/>	
Address of Organization: (Street, City, State, Zip Code)	<input type="text"/>	
Requested Professional Credential:	<input type="text"/>	
Expense Amount:	\$	<input type="text"/>
Term of Professional Credential:	<input type="text"/>	To <input type="text"/>

For advance approval requests only:

If this request is for an anticipated professional credential, what is the expected date of completion?

I understand that if I do not successfully complete the requirements to obtain the professional credential, I will not be reimbursed for incurred expenses. **Employee - please initial in box.**

Employee Official Position Title

I am a credentialed health professional which **requires** licensure in order to provide clinical care and the provision of clinical care is required as a part of my official duties **OR**

The professional credential above directly relates to the duties of my position.

If obtaining the professional credential is not **required**, briefly describe how the professional credential directly relates to the duties of the position.

I hereby request reimbursement for the above professional credential in accordance with NIH implementing policy. I have attached the required supporting documentation.

Employee Signature Date

Recommending and Approving Official:

The professional credential above directly relates to the mission, goals, and objectives of the NIH. I hereby recommend reimbursement in accordance with 5 U.S.C. § 5757 (a) and NIH implementing policy and NIH Delegation of Authority Human Resources #21, entitled "Use of Appropriated Funds to Pay for Professional Licensure, Certification, Accreditation, Examination, and Related Expenses."

Recommended Reimbursement Amount: \$

Recommending Official Signature Date

Approving Official Signature Date

Note: This approval must be retained in the purchase or reimbursement file. A copy of the approved package should be emailed to: CSSED@mail.nih.gov.