R0311U0704

# SESSIONAL PAYMENT AND EXPENSE FORM – PSP

A GPSC Initiative

For completion by all persons authorized to claim sessional fees and payments for participation in a Practice Support Program Learning Module. Please submit one form for each Action Period or Learning Session.

| Personal Information | | Reason for Claim | |
|---|---|---|---|
| | | **PSP Coordinator please complete this section** ALL FIELDS REQUIRED | |
| MSP Number: | | **Health Authority:** | FH IH NH VCH VIHA |
| Physician Name: | | **PSP Coordinator:** | |
| Practice Name: | | **PSP Module:** | |
| MOA : | | **Meeting Type:** | (LS# or AP# ) |
| Address: | | **Place:** | |
| City: | Email: | **Date:** | |
| Province: | Telephone: | **Meeting Time:** | (number of hours) |

| LEARNING SESSION | | | ACTION PERIOD |
|---|---|---|---|
| **Sessional** (Meeting time only) | | | Billable at or after the LS where AP changes are reported |
| Specialist | ☐ **1 session (478.66) OR** _____ **hours ($136.76/hr)** | **OR** | ☐ **Action Period no. _____ COMPLETE** |
| | **LS no. _____** | | |

| **EXPENSES** ***(original receipts required)*** | **GST** | **Total Amount** ***(Less GST)*** |
|---|---|---|
| Accommodation (prior approval required) | | |
| Taxi (no reimbursement for parking) | | |
| Auto KM @ $.50 per km (if one-way travel exceeds 50km) | No GST | |
| * Please note that when MOAs attend sessions out of office hours, they should be reimbursed at the $20 per hour rate. | | |
| **TOTAL EXPENSES CLAIMED** | | |

| For Office Use Only | | |
|---|---|---|
| GST | Amount (less GST) | Account Codes |
| | | |
| | | |
| | | |
| Total: | | |
| Finance Approval: | | |
| Date: | | |

Claimant's Signature

BCMA Authorized Signature

## CONDITION OF ACCEPTANCE (REQUIRED)

I understand that only practicing Specialist Physicians may claim reimbursement for Practice Support Program learning sessions and action periods, and confirm that I am currently a practicing Specialist Physician.

I hereby certify that the information provided on and with this application is truthful and accurate and that I have not and will not make a claim from any other fund for the same expense. I also verify that these expenses are for the purpose of attending a Practice Support Program learning session or participating in an action period, in accordance with the agreement between the BCMA and the Ministry of Health. I confirm that I am currently paid by MSP on a fee-for-service, sessional basis or payment under a service contract. I understand that if I have received payment from another source to cover the same time period I do not qualify for reimbursement under this program.

I confirm that I attended the learning session dated above. **SPECIALIST PHYSICIAN'S SIGNATURE** _____

**OR**

I confirm that during this action period I have tested in my practice and reported on the changes described during the previous learning session.

**SPECIALIST PHYSICIAN'S SIGNATURE** _____

**DEADLINE: Sessional Forms must be submitted within six (3) months of the meeting date.**

Attention: PSP Provincial Coordinating Office
Suite 115 1665 West Broadway, Vancouver, BC V6J 5A4

Email: psp@bcma.bc.ca
T. 604.638.2864 F. 604.638.2939 www.pspbc.ca