INDIANA UNIVERSITY
DEPARTMENT OF FAMILY MEDICINE
School of Medicine

Travel Authorization Form

Note: Any (domestic or international)university affiliated or sponsored travel is currently banned indefinitely. This form should be used for virtual conferences.

Resident

Name: _____

Conference Title: _____

Dates of Trip: _____

Presentation Day (if applicable):_____

Necessary Arrival Time: _____
(The university allows day before and after presentation date for travel time.)

Is This Trip Related To: ☐ Conf. Presn. ☐ Teaching Presn. ☐ Chapters/Textbooks ☐ Other Pubs. ☐ Research Part. ☐ PMID

Destination: _____

☐ I prefer to book my own mode of travel. ☐ I prefer to book my own lodging.

Mode of Travel: ☐ Flight ☐ Rental* ☐ Personal Vehicle ☐ Bus ☐ Other:_____

Preferred Depart Time: ☐ Morning ☐ Midday ☐ Afternoon ☐ Evening

Preferred Return Time: ☐ Morning ☐ Midday ☐ Afternoon ☐ Evening

*For Rental only – Desired pickup zip code: _____ Number of Travelers: _____

Lodging: Department will rent a room at the conference hotel or closest available hotel
(Conference hotel blocks are not available via department bookings. If you prefer a guaranteed space at the conference hotel you will need to book the hotel independently and submit for reimbursement AFTER the trip is taken.)

Conference Schedule Web Link: _____

Early Bird Registration Deadline: _____

Already Registered?: ☐ Yes ☒ No
(If "No", attach completed registration form document or online screenshots. If "Yes", attach program director approval.)

Additional Notes:

Complete above and conference registration form (screenshots, pdf, images, etc. are acceptable for the registration form) and submit to fammfin@iupui.edu (or iumfamres@IUHealth.org if resident or clinical faculty at Methodist residency) or your assigned admin (if non-clinical faculty or staff) prior to start date. If changes are made after initial submission, rates may increase and availability may be limited. The program director may determine increased costs from changes in submissions be the responsibility of the traveler.

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Scheduler Use – for Clinical Faculty or Residents

Traveler Name: _____

Approved Travel Dates: _____ Initials of Scheduler:_____
(Once travel dates are reviewed and entered above by scheduler, enter time off in scheduling software and email form to iumfamres@IUHealth.org.)

Support Staff Use

Traveler Name: _____

Account Number: _____

Registration Fee: _____

Total Estimated Cost of Trip: _____
(Registration Fee, Lodging, Transportation, Per Diem, Etc.)

Travel Arranger Name: _____
(Arranger completes above and sends to program director for review and final approval)

Program Director Use

☐ Approved ☐ Declined

If Approved, Trip Expenses Limited to: _____

Program Director Signature: _____
(If approved, sign on behalf of program director and send form to fammfin@iupui.edu. The finance team will begin processing request, determine CME funds if applicable, and return form to the appropriate parties. If denied, return to requestor with "Declined" checked but without signature.)