CAROLINA THERAPY SERVICES

C.E.R.

Continuing Education Requisition

Employee: _____ OT COTA PT PTA SLP

Years/Months of Service: _____ Facility _____

Course Title: _____

Course Sponsor: _____ CEU Amount: _____

Date/s of Course: _____ (attach brochure or pertinent info)

Location of Course: _____

Itemized Expenses	Estimated Cost
Tuition	
Accommodations	
Travel (Specify Type)	
Meals	
Others	
Total Expense Requested	

Justification for Course:

_____

_____

Total Number of Days Off: _____

Therapy Coverage:

_____

_____

I understand that I will be charged PTO for this time and that I will not be paid if I do not have PTO available.

My signature below indicates that I agree to work full time with Carolina Therapy Services for the term of one (1) year following this Continuing Education Event or a pro-rated repayment of expenses will be due to Carolina Therapy Services upon my resignation.

I further understand that a two (2) year commitment is required when my Continuing Education and reimbursement of professional licenses and/or membership dues exceed $800.00 in any calendar year.

_____
Employee/Date

_____
Clinical Specialist/Date

_____
Corporate Director/Date

_____
Area Director/Date

Approved ☐ _____ Amount

Denied ☐

Total Amount Calendar Year to Date _____
(including this CER/licenses & membership dues)