

**ST. FRANCIS MEDICAL CENTER SCHOOL OF NURSING
ALUMNI ASSOCIATION
REQUEST FOR CONTINUING EDUCATION PROGRAM**

RESTRICTED TO PAID AND GOLD MEMBERS ONLY

Name: _____ Class: _____

Address: _____

Phone: _____

I am requesting payment to attend the following educational/professional program/conference:

Title: _____

Cost of Program/Conference: _____

Amount of Request: (**\$300.00 limit**) _____

Please discuss the benefit of attending this program/conference: (attach conference brochure)

Please select one:

____ I have already sent in payment and wish to be reimbursed (must attach proof of payment.) Please mail reimbursement to:

____ Please send payment for the program directly to:

Please mail this request at least one (1) month prior to the event to:
St. Francis Nursing Alumni Association
P. O. Box 40182
Pittsburgh, Pa. 15201