Ontario

Ministry of Health and Long-Term Care

2012 CME Program Course Claim Form
Funding Year January 1, 2012 – December 31, 2012

Submit your completed claim form to the email or postal address provided at the bottom of this form by April 30, 2013. Incomplete or unsigned claim forms or claim forms without required documentation will be returned.

Name: _____ OHIP#:_____ Claim # _____
(Last Name, First Name) *(Office Use Only)*

RIO2008 Score for office address: _____
Find your RIO score at https://www.oma.org/PublicApp/nlp/NLPWF003.aspx

Primary Office Address in 2012:
_____ Tel: _____
_____ Fax: _____
_____ E-Mail: _____

Mail my cheque to my home address [ ] *If you choose this option, you must provide your home address at the bottom of this form or it will be mailed to your office address.*

In 2012 my practice is: Full Time [ ] Part Time [ ] Locum [ ] Patient Care Hours/Week: _____

I have applied for the Northern Physician Retention Initiative Yes ☐ No ☐

Course Name: _____
(Please use a separate form for each course)

Course Date(s):_____ Course Location:_____

Submission Deadline for Reimbursement Claim is April 30, 2013

*Please refer to the 2012 CME Guidelines before completing this claim form. You **must** submit proof of attendance at the course and a course agenda with this form; if your course is part of a CME vacation event (i.e. cruise, golf, ski, etc. package), you must submit an itinerary. Do **NOT** submit receipts or proof of payment; original receipts will be returned to you. However, you **must** retain your receipts and proof of payment as the Ministry may audit any reimbursed claim.*

Claim Enter the amount claimed for each applicable item	**Allowable Expenses**	***For Office Use Only*** Entitlement Amount $ _____
Course Registration Fees (please check below) Proof of Attendance [ ] Course Agenda/Outline [ ] Itinerary (CME vacation event) [ ] **Total Claimed:** $_____ in Canadian funds	• CME courses accredited by the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons (RCPSC) • **You must submit proof of attendance and a course agenda supplied by the sponsor that specifies date, location and confirmation of CME credits or hours as part of your application; if your course is part of a CME vacation event, you must submit an itinerary**	Awarded: $_____ Discrepancy: $_____ Reason:
Transportation (economy rates) Airline Ticket $_____ Train/Bus Ticket $_____ Personal car: #km _____ $_____ Car rental $_____ Parking/Taxi $_____ **Total Claimed:** $_____ in Canadian funds	• Travel in Canada: economy fares only for flights, trains and buses; travel to and from the nearest airport • International travel: maximum $1,000 per course (this includes economy airfare, car rental, parking/taxi, travel to and from airports) • Personal car: acceptable for travel in Canada and the U.S; mileage paid at 46¢/km up to a maximum of $1,000; gas expenses are not reimbursed separately, but are included in the mileage rate • Car rental: a maximum of $45/day, includes insurance, taxes, gas and mileage; based on the distance from the physician's home to the course location, a day before and a day after the course may be reimbursed • Parking/Taxi: maximum of $25/day	Awarded: $_____ Discrepancy: $_____ Reason:

NAME:_____ **OHIP#**_____ **CLAIM#**_____
(Office Use Only)

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Claim Enter the amount claimed for each applicable item	**Allowable Expenses**	***For Office Use Only*** Entitlement Amount $ _____
Accommodation Hotel # of nights:_____ $_____ Shared accommodation # of nights:_____ $_____ **Total Claimed: $**_____ in Canadian funds	• Maximum of $200 (incl. taxes) per night. Based on the distance from the physicians' home or practice to the course location, one night prior to and/or after a course may be reimbursed	Awarded: $_____ Discrepancy: $_____ Reason:
Meals Course days # ____ $_____ Travel days # _____ $_____ **Total Claimed: $**_____ in Canadian funds	• Maximum of $60/day (including taxes) calculated in half day increments • Alcohol is not covered	Awarded: $_____ Discrepancy: $_____ Reason:
Income Replacement I have regular office hours on Saturdays: Yes [ ] No [ ] Course days # ____ $_____ Travel days # _____ $_____ **Total Claimed: $**_____ in Canadian funds	• Maximum of $300 per day calculated in half day increments • Income replacement cannot be claimed for evenings or weekends (exception: Saturday can be claimed, but only if it is a regular working day; Sunday is <u>not</u> eligible for income replacement) • Physicians in harmonized primary care models must bill $2,400 in service enhancement fees through their primary care models before claiming income replacement (the "Income Replacement" row at the bottom of this table must be filled in)	Awarded: $_____ Discrepancy: $_____ Reason:
TOTAL CLAIMED: $_____ in Canadian funds		**TOTAL AWARDED: $**_____ **TOTAL DISCREPANCY: $**_____

Income Replacement (weekdays only, unless regular office hours on Saturdays)

Physicians enrolled in a harmonized primary care model must bill $2,400 in service enhancement fees through their primary care model before they can claim income replacement from the CME Program.

I am registered in a primary care model: Yes [ ] No [ ]

If yes:

- I am registered in one of the following harmonized primary care models:
  FHN [ ] FHO [ ] BSM [ ] GHC [ ] RNPGA [ ] WHA [ ] Other (please specify):_____
- I have used $2,400 in service enhancement fees through my primary care model (please check one): Yes [ ] No [ ]

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Funding Year January 1, 2012 – December 31, 2012

NAME: _____ **OHIP#**_____ **CLAIM#**_____
(Office Use Only)

Mail my cheque to:_____

_____

_____

Consent and Declaration:

In signing this form, I confirm that all information provided, including the expenses described, is true and accurate and that I have not been reimbursed from any other source for the expenses claimed herein.

I understand that the Ministry of Health and Long-Term Care will validate the amount of service enhancement fees I have billed under my primary care model between January 1, 2012 and December 31, 2012.

I understand that I must retain all receipts and proof of payment for expenses reimbursed through this claim and that the Ministry of Health and Long-Term Care may audit this claim and request repayment for any expense that I cannot validate with a receipt or proof of payment.

PHYSICIAN SIGNATURE: _____ **DATE:** _____

Please e-mail or mail your signed claim form and all required documentation by **April 30, 2013** to:

CME Program
Ministry of Health and Long-Term Care
1075 Bay Street, Suite 301
Toronto ON M7A 0A5
E-mail cme@ontario.ca
Tel: (416) 326-9052

NOTE: Incomplete or unsigned claim forms or claims without required documentation will be returned.

For office use only:

Assigned to: _____ Date Assigned:_____ Date Completed: _____

Entitlement Level $_____ YTD Awarded: $_____ YTD + Current Award $_____

CME Validation:_____ Date Approved: _____