Master of Public Health (MPH) Program
Student Travel Award Budget Form

Please Type or Print Neatly.

Name: Provide your complete name.

Title (check one): ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Suffix (if applicable): _____

Last/Family Name: _____ First/Given Name: _____

Experience Details:

Experience Location: _____ Agency: _____

Preceptor: _____ Experience Name: _____

Travel Dates:

Departure: _____ Return: _____

Anticipated Expenditures:

_____	**Airfare**
_____	**Rail fees**
_____	**Ground Transportation**
_____	**Mileage**
_____	**Housing**
_____	**Program/training registration**
_____	**Meals during the experience**
_____	**Vaccination Fees**
_____	**Visa**
_____	**Other:** _____
_____	**Other:** _____
_____	**Other:** _____
_____	TOTAL

Reimbursement will occur *after* the experience and once the student provides the required documentation for reimbursement. The University requires original receipts.

Submit the completed form to: Kara Longo at klongo@som.umaryland.edu

If questions arise, email Kara Longo (klongo@som.umaryland.edu).