DATE: ______________________________

TO: Emory University School of Medicine

RE: Request for Payment

I performed as a Standardized patient for OSCE - ______________________

Supervisor: Connie Coralli, Clinical Skills Associate Director

Supervisor Signature: ____

I am requesting payment for __________ hours at $20.00 per hour for the following training and performance sessions:

Date	Start Time	Stop Time	Total Hours

In addition, I am requesting $ _____ for parking reimbursement. I have attached receipts.

Please send the check to the address below:

Name: ______________________________________

Address: ______________________________________

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Phone: ( ) - ______________________ **Email:** ____________________________

Signature: ______________________________________

Thank you for the opportunity to participate in this program and I look forward to working with you again.