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| White Plains Hospital | **ORIGINAL DATE: 10/04/2015**<br>**REVISED DATE: 12/31/2018** |
| **SUBJECT:**<br>**CME/CONFERENCE/CERTIFICATION/LICENSE REIMBURSEMENT FOR EMPLOYED PHYSICIANS** | **REVIEWERS:**<br>**MEDICAL DIRECTOR, EVP**<br>**VP BUSINESS DEVELOPMENT** |
| **INITIATOR: DAVID BIGHAM (HR DIR/PART WPPA PHYSICIANS)**<br><br>**APPROVED: DIANE WOOLLEY (SVP, CHIEF HR OFFICER)** | **PAGE: 1 OF 1** |

**Purpose:**

To provide education leave for Continuing Medical Education (CME) and reimbursement for expenses related to CME, Conferences, Certifications and License renewals to all full-time and part-time employed physicians.

**Policy:**

White Plains Hospital (WPH) shall, on an annual basis, grant education leave up to 5 days (40 hours) with pay for all full-time employed physicians and up to 20 hours for all part-time employed physicians.

WPH shall, upon presentation of receipts, reimburse each employed physician for bona fide expenses (including conference costs, travel and accommodation expenses, educational materials and journals, Certifications, DEA and New York State Medical License renewal) up to the amount of $2,500 for all full-time physicians and up to $1,250 for all part-time physicians for each calendar year. Expenses must be incurred during the calendar year in which reimbursement is requested and are subject to VP approval.

For periods of employment of less than one year (as in the initial year of employment), the reimbursement amount shall be pro-rated by the number of full months of employment completed at the time of reimbursement. This pro-ratio may be waived with the approval of the Vice President.

Unused portions of the eligible amount as of December 31st of each calendar year cannot be carried forward into the next calendar year. Reimbursement is done throughout the year. Reimbursement will be approved for only those certifications and licenses that expired while employed by White Plains Hospital.

**Procedure:**

Physicians shall submit CME Report Form along with proof of payment to their Division Administrator for reimbursement within 90 days of payment or completion of eligible expenses.

**WHITE PLAINS HOSPITAL**
**CME REPORT FORM**

_____ _____ _____
LAST NAME FIRST NAME DATE

ADDRESS:
_____

_____

SOCIAL SECURITY #:
_____

PHONE NUMBER:
_____

I hereby apply for reimbursement for the following CME course(s).

_____
SIGNATURE Date

**NOTE: YOU MUST SUBMIT A COPY OF THE CME PROGRAMS, EVIDENCE OF PAYMENT AND CERTIFICATE OF SUCCESSFUL COMPLETION WITH THIS FORM IN ORDER FOR YOUR REIMBURSEMENT TO BE PROCESSED.**

COURSE FEE $_____

AMOUNT REIMBURSED $_____