

# TCTI The Counseling Team International

74-075 El Paseo A-16 Palm Desert, CA 92260

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## AREA CLINICIAN MULTI-USE: **Training or Trauma** **SERVICE RECEIPT – DEA EAP**

(Please use form #3 for clinical services)

PLEASE TYPE OR PRINT CLEARLY

Case Number: \_\_\_\_\_ Date: \_\_\_\_\_ A/C Name: \_\_\_\_\_

1. CLINICAL BRIEFING (trauma) SERVICES: Type of Trauma:     Operational     Non-Operational

A. Date of Session: \_\_\_\_\_ Debriefing Location:     Your Office     On Site     Other (Describe Below)\*

B. Session #: \_\_\_\_\_ (1-4) Session Duration: \_\_\_\_\_ Travel Time: \_\_\_\_\_ (Hours or ¼ hrs)

C. Clinical Briefing Services Provided to:     Individual     Group     Family

D. Number of People Debriefed: \_\_\_\_\_

E. Comments:

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2. TRAINING SERVICES PERFORMED:

A. Training No. \_\_\_\_\_

B. Dates of Training: \_\_\_\_\_ Preparation Time: \_\_\_\_\_ Training Hours: \_\_\_\_\_ Travel Hours: \_\_\_\_\_

C. Training Subject: \_\_\_\_\_ Location of Training: \_\_\_\_\_

D. Number of Managers Trained: \_\_\_\_\_ Number of Employees Trained: \_\_\_\_\_

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EXPENSE REIMBURSEMENT (Please send receipts along with this form)

Mileage: \_\_\_\_\_ Rental Car: \$ \_\_\_\_\_ Per Diem: \$ \_\_\_\_\_ Lodging: \_\_\_\_\_

Airfare: \$ \_\_\_\_\_ Tolls/Parking: \$ \_\_\_\_\_ Other: \$ \_\_\_\_\_

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ACKNOWLEDGEMENT THAT SERVICES WERE RECEIVED AS LISTED ABOVE:

\_\_\_\_\_  
Signature of Manager (Training)

\_\_\_\_\_  
Print Name of Manager

Please Make Copies As Needed - FORM # 3b