



The Counseling Team International  
 41750 Rancho Las Palmas Dr. Ste #O-2  
 Rancho Mirage, CA 92270  
 Ph: (800)651-1021 Fax: (949)855-7575  
 Email: [deaeapbilling@thecounselingteam.com](mailto:deaeapbilling@thecounselingteam.com)



## AREA CLINICIAN MULTI-USE SERVICE RECEIPT

*For Briefings, Trainings and Trauma Response*

Case Number: \_\_\_\_\_ Date: \_\_\_\_\_ Clinician Name: \_\_\_\_\_

Requesting SAC/ASAC/DTC or RAC: \_\_\_\_\_

Acknowledgement of Services Rendered Requires SAC/ASAC/RAC signature below:

Print Name of Manager	Signature of Manager	Date Signed
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1. **CLINICAL BRIEFING (trauma) SERVICES:** Type of Trauma:     Operational     Non-Operational

A. Date of Briefing: \_\_\_\_\_ Briefing Location:    Clinician Office    DEA office    Other: \_\_\_\_\_

B. Session #: \_\_\_\_\_ (1-4)    Session Duration: \_\_\_\_\_

C. Clinical Briefing Services Provided to:    Individual    Group    Family

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

E. Comments: \_\_\_\_\_

2. **TRAINING SERVICES PERFORMED:**

A. Training Title: \_\_\_\_\_

B. Date of Training: \_\_\_\_\_    Preparation Time: \_\_\_\_\_    Training Duration: \_\_\_\_\_

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

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

3. **EXPENSE REIMBURSEMENT** (Please send receipts along with this form)

TOTAL TRAVEL TIME (roundtrip/combined): \_\_\_\_\_ **\*Include totals from Form#3C if you traveled to multiple locations\***

TOTAL MILES TRAVELED (roundtrip/combined): \_\_\_\_\_ **\*Include totals from Form#3C if you traveled to multiple locations\***

Form #3C attached:    Yes    No

**\*\*PLEASE INCLUDE RECEIPTS and TRAVEL ITENERARIES FOR ITEMS LISTED BELOW:**

RENTAL CAR: \$ \_\_\_\_\_    LODGING: \$ \_\_\_\_\_

AIRFARE: \$ \_\_\_\_\_    TOLLS/PARKING: \$ \_\_\_\_\_    OTHER: \$ \_\_\_\_\_

CAB/UBER/LYFT: \$ \_\_\_\_\_ (Maximum tip allotted for reimbursement is 15%)

*For Office Use only: Per Diem: \$ \_\_\_\_\_*