The Counseling Team International
41750 Rancho Las Palmas Dr. Ste #O-2
Rancho Mirage, CA 92270
Ph: (800)651-1021 Fax: (760) 636-0437
Email: 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**

***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. # Supervisors Briefed: ______ **# Employees Briefed:** _______ **# Family Members Briefed:** ______ **# of TTMs:** _______

E. Comments: ____

***2. TRAINING SERVICES PERFORMED*:**

A. Training Title: ____

B. Date of Training: ____________ **Preparation Time:** ________ **Training Duration:** _______

C. Location of Training: ____

D. # Managers Trained: ________________ **# Employees Trained:** ________________ **# of TTMs:**___________

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: $*______________