

ALBERT EINSTEIN COLLEGE OF MEDICINE
OF YESHIVA UNIVERSITY

RELOCATION EXPENSES AUTHORIZATION

Ref: Administrative Policy No. 4.6
Reimbursement of Relocation Expenses

Date _____

Name of Employees: _____

Title: _____ Per Annum Salary \$ _____

Approved Source of Salary: _____

Current Address: _____

Prospective Address (if known): _____
city state

city state

Expected Date of Move: _____

Estimated Cost of Move (if known): \$ _____

Source of Funds: _____

Requested by: _____ Dept: _____
Signature of Chairman

----- DO NOT WRITE BELOW THIS LINE - FINANCE DEPARTMENT USE ONLY -----

To Requestor:

Maximum relocation reimbursement allowable: \$ _____

Maximum travel reimbursement allowable: \$ _____

Total: \$ _____

- () Approved
() Disapproved

Explanation (if disapproved): _____

By _____ Date _____
Director of Finance

INSTRUCTIONS: Submit this form in duplicate to the Director of Finance three (3) weeks prior to any commitment being made to any prospective employee regarding relocation expenses. The Director of Finance will communicate with the requesting department.