ADVANCE AUTHORIZATION FOR DIRECTLY SPONSORED EVENT (Appendix A-2)

Please refer to PHS Policy and Procedures for Employee Business Expense Section III G.

GENERAL INFORMATION

Department/Group Sponsoring the event ______________________________

Cost Center / Fund ______________________________ Are expenses Budgeted? YES NO

Event Requestor ____________________ Phone ____________________ Email ____________________

BUSINESS PURPOSE

Description of event, including business purpose (i.e., business retreat, holiday party, department function), date and location:

If this is a daytime event (held between 6:00 am and 5:00 pm), is the venue part of the Partners HealthCare Preferred Hotel program? If not, contact travel@partners.org

❒ Business Retreat
❒ Educational Event
❒ Holiday Party
❒ Recruitment
❒ Other ______________________________

Business Purpose ______________________________

____

Event Venue (hotel, conference center, etc.) ____________________

____

Date(s) & Time(s) of Event ____________________

Outside Vendor(s) utilized for event ____________________

____

*** IRS requires the agenda of the meeting or a brief description of business purpose (please attach.)**

EVENT ATTENDEES

Total Number of Attendees ____________________ Number of Employees ____________________

Attach List of Attendees (Required) Number of Non-employees ____________________

Please describe business purpose of non-employees attending (IRS requires)

____

____

EVENT COSTS

Food & Beverage (Total) ____________________

Room Rental ____________________

Entertainment ____________________

Audio/visual ____________________

Parking ____________________

Other ____________________

Event Budget Total ____________________

*** Per person cost (Food & Beverage only)**

Check all boxes that apply:

❒ Breaks - per person cost $ ____________________

❒ Breakfast - per person cost $ ____________________

❒ Lunch - per person cost $ ____________________

❒ Dinner - per person cost $ ____________________

Food & Beverage (Total per person cost) $ ____________________

* If necessary please attach a spreadsheet for multiple meals/multiple days with budget details.

APPROVALS

PLEASE NOTE: Payment will not be processed without special approval.

	General	Special **(Required)**
Name		
Signature		
Date		
Title		

Please keep a copy of this form and attach to all invoices related to this event.

***Department of Radiology Restriction* -** Completed form must be received four weeks before event date. Contracts must not be executed or expenses incurred related to the event until both approvals have been obtained.