Print Form

Los Angeles County

High Desert Health System

Department of Nursing

TRAINING TIME REQUEST - RN

Management will allow the **full-time permanent REGISTERED NURSE (RN)** a maximum of 40 hours of County paid time during the three year term of the current MOU Agreement for the purpose of meeting mandatory continuing education requirements.

Management will allow **permanent part-time RNs, who work at least 20 hours per week on a continuing basis**, up to a maximum of 20 hours of County time during the three year term of this Agreement for the purpose of meeting mandatory continuing education requirements.

Each RN requesting time to attend seminars, workshops, or home study courses as stated above, ***MUST SUBMIT THIS FORM ALONG WITH THE COURSES OUTLINE*** **to the Nursing Education Department at least two (2) weeks prior to the scheduled continuing education event.**

Name:	
Seminar:	***Location:***
Date of Seminar: Start: / End:	***Hours Requested:***

I understand that by signing this request, I agree to ***provide a certificate of completion to the Nursing Education Department within two (2) weeks*** *after the seminar/workshop or* proof of submission of a home study course for CEUs. I further understand that ***failure to comply*** *with submission of this proof of attendance, will result in time a time card adjustment or reflect* ***AWOP*** ***(ABSENT WITHOUT PAY).***

Employees Signature: _____ Date: _____

Manager's Signature: _____ Date: _____

Hours used from _____ to present:	Verified by:	*Date:*
Hours Approved:	Approved by:	Date:

☐ *Request Denied by:* *Date:*

Comments: _____

_____

_____

WINWORD/FORMS/T-TIMERN -

Reset Form

Print Form

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Los Angeles County

High Desert Health System

Department of Nursing

TRAINING TIME REQUEST - LVN

Management will allow the **full-time permanent LICENSED VOCATIONAL NURSE (LVN)** County paid time, on-the-job training (or in-house offerings) accredited for meeting applicable state relicensure or recertification requirements will be granted at the discretion of the Nurse Manager and Chief Nursing Officer or designee, during the three year term of this Agreement for the purpose of meeting mandatory continuing education requirements.

Each LVN requesting time to attend seminars, workshops, or home study courses as stated above, ***MUST SUBMIT THIS FORM ALONG WITH THE COURSES OUTLINE*** **to the Nursing Education Department at least two (2) weeks prior to the scheduled continuing education event.**

Name:	
Seminar:	***Location:***
Date of Seminar: Start: End:	***Hours Requested:***

I understand that by signing this request, I agree to ***provide a certificate of completion to the Nursing Education Department within two (2) weeks*** *after the seminar/workshop or* proof of submission of a home study course for CEUs. I further understand that ***failure to comply*** *with submission of this proof of attendance, will result in time a time card adjustment or reflect* ***AWOP*** ***(ABSENT WITHOUT PAY).***

Employees Signature: _____ Date: _____

Manager's Signature: _____ Date: _____

Hours used from_____to present:	Verified by:	*Date:*
Hours Approved:	Approved by:	Date:

☐ *Request Denied by:* *Date:*

Comments: _____

WINWORD-FORMS-TTIME LVN

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REQUEST FOR APPROVAL OF TRAINING

Assistant director Date	CONTROL NO. DEPT. ACCT. NO.

1. TITLE OF PROGRAM	2. DEPARTMENT Name & No.	3. NO. OF TRAINEES	DATE RECEIVED
5. LOCATION OF TRAINING	6. DATE(S) OF TRAINING	4. □ SALARY □ REGISTRATION □ SUBSISTENCE □ TRAVEL	

7. COST

Registration: $_____/Per X_____ =$
Subsistence: $_____/Per X_____ =$
Travel: $_____/Per X_____ =$
Consultant Fee: $_____/Per X_____=$

TOTAL COST: $_____

REIMBURSEMENT: $_____

COUNTY COST: $_____

8. TRAINEES:

Name Classification

9. RESERVATIONS AND DEADLINE IF ANY:

JUSTIFICATION: (Continue on separate sheet if needed.)

DIVISION HEAD SIGNATURE:	DATE	ADMINISTRATOR SIGNATURE	DATE	CEO, VALLEYCARE SIGNATURE	DATE

This card must be submitted within 4 weeks of the training date.

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

TRAVEL/TRAINING COST ESTIMATE

FACILITY/UNIT:_____ Control #:_____
NAME:_____
DESTINATION:_____
DATE OF TRIP (all inclusive):_____

ESTIMATED COST

Airfare	$_____
Car Rental	$_____
Ground Transportation	$_____
Registration	$_____
Lodging	$_____
Meals	$_____
Capitol City Allowance	$_____
Porterage	$_____
Other -	$_____
ESTIMATED COST OF TRIP	**$**_____
FULL YEAR ALLOCATION	$_____
YTD EXPENDITURES (Including this trip)	$_____
BALANCE OF ALLOCATION	**$**_____

TRNG.FORM