



# Payment Requisition

Accounting Services  
1100 Harley Court  
10045-111 St.  
Edmonton, Alberta T5K 2M5

APPLICANT COPY

**I PAYEE INFORMATION (Check one only)**     Vendor     Patient     Employee (EE number                     )

Invoice Date	Invoice Number	Section 17(1)
Vendor Number (or S.I.N.)	Vendor Name <i>Dr-G Predu</i>	
Address	City	
Province/State	Postal Code	Country

**II PAYMENT DETAILS**

Reason for payment *CMHA Insurance*    PO #

Is this a contract payment?     Yes (Attach copy of contract if not previously forwarded)     No

If this is a contract payment, what is the contract date?    Number

Have goods / services been received?     Yes, When?     No

Are original attachments to be mailed with cheque? (Note 2)     Yes     No

**III EXPENSE CODES (IN ORACLE FINANCIAL SYSTEM FORMAT)**    (Departments must provide Complete Coding)

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050004	Account e.g. 69500000	Expense Sub-Total	GST if applicable	Total Payment
<i>201</i>	<i>0007</i>	<i>71550300036</i>	<i>66020000</i>	<i>\$ 1680.00</i>	\$	<i>\$ 1680.00</i>
				\$	\$	\$
				\$	\$	\$
				\$	\$	\$
				\$	\$	\$
				\$	\$	\$
				\$	\$	\$
<input checked="" type="checkbox"/> Canadian <input type="checkbox"/> U.S. <input type="checkbox"/> Other				<b>TOTAL</b>	<i>\$ 1680</i>	<i>\$ 1680</i>

Capital Health

**RECEIVED**

MAR 21 2005

ACCOUNTS  
PAYABLE

**IV AUTHORIZATION**

I confirm that the above items have not been previously paid and the expenses related only to Capital Health business.

Requisitioned by (Print name) <i>Lavera Sebalsky</i>	Phone # <i>413-7946</i>
(Signature) <i>L Sebalsky</i>	Date <i>Feb 28/05</i>
Approved by (Print name) <i>Michele Lakey</i>	Phone # <i>407-1671</i>
(Signature) <i>Michele Lakey</i>	Date <i>Mar 2/05</i>
Approved by (Print name) <i>[Signature]</i>	Phone #
(Signature)	Date

**AUTHORIZATIONS SHOULD BE IN ACCORDANCE WITH SIGNING AUTHORITY POLICY NUMBER FINANCE 4.1**

Notes:

- All employee payments will be made electronically based on payroll banking information.
- All cheques and attachments will be mailed out by Accounting Services. Cheques will NOT be pulled and returned to departments for mailing.
- Fully completed payment requisitions received in Accounting Services by **MONDAY, 4:00 p.m.** will be processed that week.
- Incomplete/improperly authorized payment requisitions will be returned without processing



THE CANADIAN L'ASSOCIATION  
MEDICAL CANADIENNE  
PROTECTIVE DE PROTECTION  
ASSOCIATION MÉDICALE

APPLICANT COPY

ANNUAL RECEIPT

Membership fee in a mutual defence organization that provides malpractice protection and advice for its members.

Member number: [redacted] Section 17(1)

Non Responsive

Paid in	For year	\$ Amount
		[redacted]
2004	2005	1,680.00

DR GERALD PREDY  
300-10216 124 ST NW  
EDMONTON AB T5N 4A3

Effective 2002, Quebec fees include 9% QST.

Mailing Address: P.O. Box 8225, Station T, Ottawa, ON K1G 3H7  
Street Address: 875 Carling Ave., Ottawa, ON K1S 5P1  
Telephone: (613) 725-2000, 1-800-267-6522  
Facsimile: (613) 725-1300 Web Site: [www.cmpa-acpm.ca](http://www.cmpa-acpm.ca)

Adresse postale : C.P.8225, Succursale T, Ottawa ON K1G 3H7  
Adresse civique : 875, av. Carling, Ottawa, ON K1S 5P1  
Téléphone : (613) 725-2000, 1-800-267-6522  
Télécopieur : (613) 725-1300 Site Web : [www.cmpa-acpm.ca](http://www.cmpa-acpm.ca)

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**APPLICANT COPY**  
**Travel Expense Claim Form**  
 (In Canadian Dollars)  
 (To be used for all Regional and Out of Regional Travel)

*Receipts on the List*

(Please Print or Type)

Name G. PREDY Section 17(1)  Employee Number [REDACTED] ✓  
 Position MOH Oracle Cost Centre \_\_\_\_\_  
 Department Public Health Bus. Phone \_\_\_\_\_  
 Period from Feb 2/05 to \_\_\_\_\_ Health Literacy Meeting

Expenses Paid (Please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form.

	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included	DO NOT USE
Accommodation			-		
Meals			12.00	/	
Registration Fees			-		
Transportation (including parking)			224.25	/	
Other					
Mileage			16.80	/	
TOTAL			\$ 252.05		\$
Less Cash Advance					
NET			\$ 253.05	/	

**Capital Health RECEIVED**  
 MAR 21 2005  
 ACCOUNTS PAYABLE

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature [Signature] Date Feb 16/05

Approved by  
 Print Name Michele Cahay Title Sup. P. Health Service

Signature [Signature] Date Feb 18/05

Print Name \_\_\_\_\_ Title \_\_\_\_\_  
 Signature \_\_\_\_\_ Date \_\_\_\_\_

NOTE: 201-0007-7155030036: 62412000 = 253.05 ⊕

- GST amounts included in the expense claims will be calculated by Accounts Payable.
- Please ensure that the expense claim is properly authorized.
- For all employees on the payroll system, expense cheques will be deposited to employee bank account.
- For physicians, contracted employees and those not paid through the payroll system, expense cheques will be mailed through the internal mail system.
- See the other side of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Harley Court - 1100, 10045 - 111 Street, Edmonton, AB T5K 2M7)
- Out of province expenses also require approval of Chief Operating Officer or Vice President.



APPLICANT COPY

Driver: JD Date: 2-2-05  
 Unit No.: 1221 Amount: 307  
 (G.S.T. Included)

G.S.T. No. \_\_\_\_\_

"It is our pleasure to serve you. Please call again."

777-2222 777-1111

Driver: CS Date: 02/01/05  
 Unit No.: \_\_\_\_\_ Amount: 307  
 (G.S.T. Included)

G.S.T. No. \_\_\_\_\_

"It is our pleasure to serve you. Please call again."

777-2222 777-1111

EDMONTON AIRPORTS

GST# R128599770

\*\*\*\*\*  
 \*\*\*\*\*

Car park 0000001009 Phone. (780)890-8439  
 Fax. (780)890-8329

Receipt no. 0146/0727/00803 02.02.05

015100 pay parking ticket 8,00 \$  
 02.05 09:43 - 02.02.05 19:36  
 Length of stay: 0 Dy. 9 Hr. 53 Min.

total amount 8,00 \$

accepted total 20,00 \$  
 change 12,00 \$  
 Tax 7,00 % 0,52 \$

Thank you for your patronage!  
 Please Come Again!  
 Open 24 hours \*\*  
 \*\* Thank you \*\*

**AIR CANADA** SPECIAL SERVICE TICKET / BILLET DE SERVICES SPECIAL

02 FEB 05

FROM: Calgary TO: Edmonton

014 4062 534 033

Section 17(1)(4)(e)





# KMT APPLICANT COPY Travel Expense Claim Form

(In Canadian Dollars)

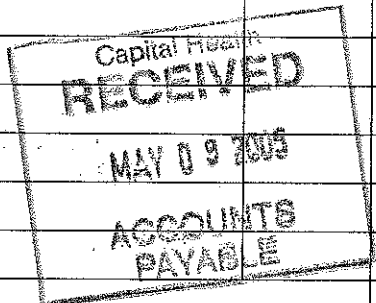
(To be used for all Regional and Out of Regional Travel)

(Please Print or Type)

Name G. Priddy Employee Number \_\_\_\_\_  
 Position Man Oracle Cost Centre s.17(1)  
 Department Public Health Division Bus. Phone 413 7600  
 Period from April 11, 2005 to April 13, 2005 Urban Public Health - Montreal

Expenses Paid (Please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form.

	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included	DO NOT USE
Accommodation			\$424.15	X	39
Meals			44.00	X	
Registration Fees					
Transportation (including parking)			251.16	X	
Other					
Mileage			21.35	X	
TOTAL			\$ 740.66		\$
Less Cash Advance					
NET			\$ 740.66		



The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature [Signature] Date April 15 2005

Approved by  
Print Name Michelle Lahey Title Senior VP, Health Services

Signature [Signature] Date \_\_\_\_\_

Print Name \_\_\_\_\_ Title \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

- NOTE:**  $201.0007 \cdot 71550300036 \cdot 62414000 = 740.66$  (P)
- GST amounts included in the expense claims will be calculated by Accounts Payable.
  - Please ensure that the expense claim is properly authorized.
  - For all employees on the payroll system, expense cheques will be deposited to employee bank account.
  - For physicians, contracted employees and those not paid through the payroll system, expense cheques will be mailed through the internal mail system.
  - See the other side of this form for expense claim limits.
  - Approved claim form with receipts should be sent to Accounts Payable (Harley Court - 1100, 10045 - 111 Street, Edmonton, AB T5K 2M7)
  - Out of province expenses also require approval of Chief Operating Officer or Vice President.

69542 45.24n [Signature]



# EDMONTON AIRPORTS

GST# R128599776

\*\*\*\*\*

\*\*\*\*\*

Car park 0000001009 Phone: (780)890-8439  
Fax: (780)890-8329

Receipt no. 0181/0727/00803 13.04.05

015100 pay parking ticket 24.00 \$  
11.04.05 06:40 - 13.04.05 20:20  
Length of stay: 2 Dy. 13 Hr. 40 Min

total amount 24.00 \$  
accepted total 24.00 \$  
Tax 1.57 \$

Thank you for your patronage:

Please Come again!

\*\* open 24 hours \*\*

\*\* Thank you \*\*

PETRO-CANADA  
AEROPORT DE JORVAL  
JORVAL  
Quebec H4Y 1G9

GST# 668827205 (514) 633-0020  
P.S.T. # 1205516618  
2005 04-13 P008000001 13.04.05

FUEL Pump 4  
Regular 22.77

Total Overall 24.00 \$

Total Paid 24.00 \$

TAXES INC.

Net Total \$ 24.00  
P.S.T. Total \$ 0.00

DEPT. SA. Obligation 000000

VISA

INVOICE 11000

AUTHORITY 9 01's.17(1), 17(4)(e.1)

Back pay

APPLICANT COPY

\*\*\*\*\*  
Saisissez votre numéro de carte de crédit  
Dites le numéro de votre carte de crédit  
pour le paiement de votre facture

Visitez notre site  
www.petrocanada.ca  
ou appelez nous  
1 800 347 0025

\*\*\*\*\*





# APPLICANT COPY

REF: RA # 155729020

s.17(1)

RATE RULES AND QUALIFICATIONS  
CA INTERNET POINT OF SALE DAILY

RENTAL LOCATION  
 MONTREAL-P.E. TRUDEAU AIRPORT  
 975 ROMEO VACHON SUITE 07-1  
 NATIONAL CAR RENTAL  
 MONTREAL N/R P-512680-1 DE MAY 1H1  
 514 436 9090

RENTAL DATE RES #  
 11-APR-2005  
 RENTAL TIME FT #  
 03:18 PM

RETURN LOCATION  
 MONTREAL-P.E. TRUDEAU AIRPORT  
 975 ROMEO VACHON SUITE 07-1  
 NATIONAL CAR RENTAL  
 MONTREAL N/R P-512680-1 DE MAY 1H1  
 514 436 9090

RETURN DATE  
 12-APR-2005  
 RETURN TIME  
 04:00 PM

VEHICLE INFORMATION  
 RESERVED PCAR Full Size 2/4 Door Cc  
 DRIVEN PCAR Full Size 2/4 Door Cc  
 CHARGED PCAR Full Size 2/4 Door Cc  
 MAKE CHEVROLET  
 MODEL MALIBU  
 COLOR WHITE ODOMETER 17344  
 PCB2602 DE VEHICLE # 5F226181  
 R4152

CHARGES	UNIT	PRICE/UNIT	CURRENT CHARGE	PAYMENTS
RENTER'S RESPONSIBILITY				VISA 3017 - Auto #
* TIME & DISTANCE	WEEK	584.90	0.00	(All Charges Are Estimate Only - Subject to change if vehicle not returned to the location on date and time specified, or if fuel tank is not full at return and fuel service option was not purchased)
* TIME & DISTANCE	Day	34.90	109.80	
* TIME & DISTANCE	Hour	19.90	0.00	
* UNLIMITED MILES/KM-TIME &	N/KM	0.00	0.00	
* LHM	Day	23.95	47.90	
* REFUELING SERVICE CHARGE	Litre	2.25	0.00	
* VEHICLE LIC FEE/AIR TAX RECOVERY			2.76	
* CONCESSION RECUP FEE 11.73 PCT @ 11.73%			19.85	
CA PRVNC'L SLS TX QUEBEC 7.50%			14.29	
CA GST & SVCS TX 7% 7.00%			12.37	

### ESTIMATED CHARGES

204.97

INITIAL

I ACCEPT OPTIONAL LOSS DAMAGE WAIVER AT \$23.95 PER DAY.

I DECLINE PERSONAL ACCIDENT INSURANCE (PAI) WITH PERSONAL EFFECTS COVERAGE (PEC).  
 I DECLINE PEACE OF MIND.

# LE WESTIN RESORT

TREMBLANT, QUÉBEC

APPLICANT COPY

1 ch. Kandahar, Mont-Tremblant (Québec) J0T 1Z0

Réservation	Unité / Unit	Invité / Guest
1RP9X8	W2420	1QI4JA
Tarif / Rate	Pers.	Dépôt / Deposit
179.00	2	424.15
Carte de crédit / Credit Card		Exp.
Arrivée / Arrival		Départ / Departure
04/11/05		04/13/05
Enregistrement de taxes / Tax Registration		
T.P.S. / G.S.T.		130 401 953
T.V.Q. / P.S.T.		101 104 742 100 01

Nom & adresse / Name & Address
Predy, Dr. Jerry American Express suite 850 10050 Jasper av enue  Edmonton, ALBERTA T5J 3R8

DATE	DESCRIPTION	FRAIS/CHARGES	PAIEMENTS/PAYMENTS
		s.17(1), 17(4)(e.1)	
03/30/05	DVISA	F3 1	106.03
04/11/05	ROOMTX Chambre/Room (taxable)	-- 1 179.00	
04/11/05	TVQ TVQ / PST	-- 1 14.80	
04/11/05	TPS TPS / GST	-- 1 12.91	
04/11/05	REDEVA AVT/TRA 3%	-- 1 5.37	
04/12/05	ROOMTX Chambre/Room (taxable)	-- 1 179.00	
04/12/05	TVQ TVQ / PST	-- 1 14.80	
04/12/05	TPS TPS / GST	-- 1 12.91	
04/12/05	REDEVA AVT/TRA 3%	-- 1 5.37	
04/13/05	PVISA	RT 1	318.12
04/11/05	WVALET Valet - Westin	s.17(1), 17(4)(e.1)- 6 10.00	
04/11/05	TVQ TVQ / PST	-- 6 0.82	
04/11/05	TPS TPS / GST	-- 6 0.71	
04/11/05	REDEV2 AVT/TRA 2%	-- 6 0.20	
04/12/05	WVALET Valet - Westin	-- 6 10.00	
04/12/05	TVQ TVQ / PST	-- 6 0.82	
04/12/05	TPS TPS / GST	-- 6 0.71	
04/12/05	REDEV2 AVT/TRA 2%	-- 6 0.20	
04/13/05	WVALET Valet - Westin	RT 6 -20.00	
04/13/05	REDEV2 AVT/TRA 2%	RT 6 -0.40	
04/13/05	TPS TPS / GST	RT 6 -1.43	
04/13/05	TVQ TVQ / PST	RT 6 -1.64	

Je m'engage personnellement à payer les frais encourus soit en partie ou en entier, à défaut de paiement complet par la compagnie, par l'association ou son représentant désigné.

I agree that my liability for this bill is not waived and agree to be held personally liable in the event that the indicated person, company or association fails to pay for any part of the full amount of these charges.

**Pour réserver votre prochaine expérience Tremblant! 1-877-TREMBLANT**  
**To reserve your next Tremblant experience, call 1-877-873-6252**

Signature :	Date :
-------------	--------

APPLICANT COPY

# LE WESTIN RESORT

TREMBLANT, QUÉBEC

1 ch. Kandahar, Mont-Tremblant (Québec) J0T 1Z0

Réservation	Unité / Unit	Invité / Guest
1RP9X8	W2420	1QI4JA
Tarif / Rate	Pers.	Dépôt / Deposit
179.00	2	424.15
Carte de crédit / Credit Card		Exp.
Arrivée / Arrival	Départ / Departure	
04/11/05	04/13/05	
Enregistrement de taxes / Tax Registration		
T.P.S. / G.S.T.	130 401 953	
T.V.Q. / P.S.T.	101 104 742 100 01	

Nom & adresse / Name & Address

Predy, Dr. Jerry  
 American Express  
 suite 850 10050 Jasper av  
 enue  
  
 Edmonton, ALBERTA T5J 3R8

DATE	DESCRIPTION	FRAIS/CHARGES	PAIEMENTS/ PAYMENTS
	Sub-Total	\$ 424.15	424.15
	Thanks, see you again soon !		
	Starwood Preferred Guest #		
	GST Total :	25.81	
	PST Total :	29.60	

Je m'engage personnellement à payer les frais encourus soit en partie ou en entier, à défaut de paiement complet par la compagnie, par l'association ou son représentant désigné.

I agree that my liability for this bill is not waived and agree to be held personally liable in the event that the indicated person, company or association fails to pay for any part of the full amount of these charges.

**Pour réserver votre prochaine expérience Tremblant ! 1-877-TREMBLANT**  
**To reserve your next Tremblant experience, call 1-877-873-6252**

Signature : \_\_\_\_\_ Date : \_\_\_\_\_



CMF-05-APR  
APPLICANT COPY

Travel Expense Claim Form

(In Canadian Dollars)

(To be used for all Regional and Out of Regional Travel)

(Please Print or Type)

Name G. Pardy Employee Number s.17(1)  
 Position MOH Oracle Cost Centre \_\_\_\_\_  
 Department Public Health Bus. Phone 413 7600  
 Period from May 25 to May 27 Western Cities Medical Officers of Health

Expenses Paid (Please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form.

	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included	DO NOT USE
Accommodation			319.20	✓	299.60 19.60
Meals			53.00	✓	0
Registration Fees			-		
Transportation (including parking)			53.75	✓	0
Other			-		
Mileage			21.70	✓	0
TOTAL			\$ 447.65		\$
Less Cash Advance			-		428.05 0
NET			\$ 447.65	✓	19.60 0

Capital Health  
RECEIVED  
JUN 20 2005  
ACCOUNTS PAYABLE

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature [Signature] Date May 30/05  
 Approved by \_\_\_\_\_  
 Print Name Michèle Pardy Title \_\_\_\_\_  
 Signature [Signature] Date \_\_\_\_\_  
 Print Name \_\_\_\_\_ Title \_\_\_\_\_  
 Signature \_\_\_\_\_ Date \_\_\_\_\_

- NOTE: 201-0007-7155030036.62914000 = 447.65 [Signature]
- GST amounts included in the expense claims will be calculated by Accounts Payable.
  - Please ensure that the expense claim is properly authorized.
  - For all employees on the payroll system, expense cheques will be deposited to employee bank account.
  - For physicians, contracted employees and those not paid through the payroll system, expense cheques will be mailed through the internal mail system.
  - See the other side of this form for expense claim limits.
  - Approved claim form with receipts should be sent to Accounts Payable (Harley Court - 1100, 10045 - 111 Street, Edmonton, AB T5K 2M7)
  - Out of province expenses also require approval of Chief Operating Officer or Vice President.



APPLICANT COPY

ROOM / CHAMBRE 0831  
 CASHIER / CAISSIER(E) 36  
 PAGE 1  
 CUSTOMER(S) / CLIENT(S) 1

350 St. Mary Ave., Winnipeg, Manitoba R3C 3J2  
 Tel.: (204) 942-0551 • Fax: (204) 943-4627

ARRIVAL / ARRIVÉE 05/25/05  
 DEPARTURE / DÉPART 05/27/05

Mr Gerry Dr Predy

CANADA

Invoice# , Delta Winnipeg, 05/27/05

DATE	DESCRIPTION	CHARGES FRAIS	CREDITS CREDITS
05/25	Room Charge	140.00	
05/25	GST Room	9.80	
05/25	PST Room	9.80	
05/26	Room Charge	140.00	
05/26	GST Room	9.80	
05/26	PST Room	9.80	
05/27	VISA XX/XX		319.20
		319.20	319.20
	s.17(1), 17(4)(e.1)	0.00 CAD	
	GST Room (7.0%) 19.60		
	GST F & B (7.0%) 0.00		
	GST Other (7.0%) 0.00		
	Total GST (7.0%) 19.60		
	GST Vendor 139445290 RT0020		

I agree that my liability for this bill is not waived and agree to be held personally liable in the event that the indicated person, company or association fails to pay for any part or the full amount of these charges. Delta agrees to transmit to credit card issuer for payment. Merchandise/or services purchased on this credit card shall not be resold for a cash refund. I have accepted delivery of The Globe and Mail. Had I refused, I would have been eligible for a \$.50 (Mon.-Fri.) and \$1.25 (Sat.) credit to my account. (At participating hotels.)

Je m'engage personnellement à acquitter les frais encourus soit en partie, soit en entier, à défaut de paiement complet par la compagnie, l'association ou son représentant désigné. Delta Hôtels convient de transmettre cette note au fournisseur de la carte de crédit pour paiement. Les achats en biens et services effectués avec cette carte de crédit ne peuvent être revendus pour un remboursement en espèces. J'ai accepté la livraison du journal The Globe and Mail. Si j'avais refusé, j'aurais pu obtenir un crédit à mon compte de 0,50 \$ par jour (du lundi au vendredi) et de 1,25 \$ le samedi. (Dans les hôtels participants.)

X

Guest's Signature / Signature du client

# EDMONTON AIRPORTS

GS# R12859776

\*\*\*\*\*  
\*\*\*\*\*

Car park 000001009 Phone. (780)890-8439  
Fax. (780)890-8329

Receipt no. 000297820000 27.05.05

015100 pay parking 22.75 \$  
25.05.05 15:03  
Length of stay 27 min.

total 22.75 \$  
22.75 \$  
22.75 \$  
22.75 \$  
22.75 \$  
22.75 \$  
22.75 \$

Thank you for your contribution  
to the development of the  
Edmonton International Airport  
\*\*\*\*\*

Thanks again!  
...and do call us  
**UNICITY TAXI LTD**  
925-3131

DATE \_\_\_\_\_  
TRIP FROM \_\_\_\_\_  
TO \_\_\_\_\_  
CAR 772 AMOUNT 16.00  
DRIVER PSA

Thanks again!  
...and do call us  
**UNICITY TAXI LTD**  
925-3131

DATE 22/05/05  
TRIP FROM BELTA Hotel  
TO \_\_\_\_\_  
CAR AMOUNT \$15  
DRIVER \_\_\_\_\_

s.17(1)







APPLICANT COPY



HOTELS & RESORTS

The Westin Ottawa ■ 11 Colonel By Drive, Ottawa, Ontario K1N 9H4 ■ Tel: (613) 560 7000 ■ Fax: (613) 234 5396

**Dr. Jerry Fredy**

c/o Suite 300 10216 124th St  
Edmonton, AB T5J 3R8  
CANADA

Arrival/Arrivée: 09/18/05  
Departure/Départ: 09/21/05

Airline Partner : AC

s.17(1)

Page: 1

Agent: 65

Room/Chambre: 1809

F O L I O 525023 The Westin Ottawa, 09/21/05 12:01

Date	Description		Charges	Credits
09/18	Room	1809	179.00	
09/18	G.S.T Room 7%		12.53	
09/18	P.S.T Room 5%		8.95	
09/18	DMF fee 2.8%		5.02	
09/18	GST on DMF 7%		0.35	
09/19	Room		179.00	
09/19	G.S.T Room 7%		12.53	
09/19	P.S.T Room 5%		8.95	
09/19	DMF fee 2.8%		5.02	
09/19	GST on DMF 7%		0.35	
09/20	Room		179.00	
09/20	G.S.T Room 7%		12.53	
09/20	P.S.T Room 5%		8.95	
09/20	DMF fee 2.8%		5.02	
09/20	GST on DMF 7%		0.35	
09/21	Visa	XX/XX		617.55
s.17(1), 17(4)(e.1)		Total:	617.55	617.55
		Balance Due:	0.00 \$	

Capture Method:Swiped

We are pleased to inform you that your Air Canada Aeroplan Program miles have been awarded.

If you are an SPG member and your points are not shown, they will be posted to your SPG account and will show on your next SPG statement.

Thank You For Choosing The Westin Ottawa

Rooms GST: 38.64

APPLICANT COPY

**WESTIN**

HOTELS & RESORTS

The Westin Ottawa ■ 11 Colonel By Drive, Ottawa, Ontario K1N 9H4 ■ Tel: (613) 560 7000 ■ Fax: (613) 234 5396

**Dr. Jerry Predy**

c/o Suite 300 10216 124th St  
Edmonton, AB T5J 3R8  
CANADA

Arrival/Arrivée: 09/18/05  
Departure/Départ: 09/21/05

Airline Partner : AC

s.17(1)

Page: 2

Agent: 65

Room/Chambre: 1809

F O L I O 525023 The Westin Ottawa, 09/21/05 12:01

Date	Description	Charges	Credits
------	-------------	---------	---------

F&B GST: 0.00  
Other GST: 0.00  
Total GST: 38.64

GST # : 861336493RT0002



# APPLICANT COPY



## Travel Expense Claim Form

(In Canadian Dollars)

(To be used for all Regional and Out of Regional Travel)

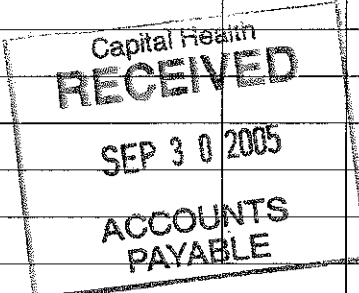
(Please Print or Type)

s.17(1)

Name Dr. Gerry Predy Employee Number \_\_\_\_\_  
 Position Medical Officer of Health Oracle Cost Centre 201000771550300036  
 Department \_\_\_\_\_ Bus. Phone 413-7600  
 Period from Sept 23/05 to Sept 23/05 Specialty Society Meetings Vancouver

Expenses Paid (Please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form.

	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included	DO NOT USE
Accommodation					
Meals			17.00		
Registration Fees					
Transportation (including parking)			82.00	✓	
Other					
Mileage			27.36	✓	
<b>TOTAL</b>			<b>\$</b>		<b>\$</b>
Less Cash Advance					
<b>NET</b>			<b>\$ 126.36</b>	✓	



The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature [Signature] Date Sept 26/05

Approved by

Print Name Michèle Lahey Title \_\_\_\_\_

Signature [Signature] Date \_\_\_\_\_

Print Name \_\_\_\_\_ Title \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**NOTE:**

201.0007.7155030036.62414000 = 126.36 (P)

- GST amounts included in the expense claims will be calculated by Accounts Payable.
- Please ensure that the expense claim is properly authorized.
- For all employees on the payroll system, expense cheques will be deposited to employee bank account.
- For physicians, contracted employees and those not paid through the payroll system, expense cheques will be mailed through the internal mail system.
- See the other side of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses also require approval of Chief Operating Officer or Vice President.



APPLICANT COPY

CASH RECEIPT  
GST # R103934949

Ferry Service / 24-Hour Airport Service



**NORTH SHORE TAXI**  
AND  
**Cadillac Cabs**

604-987-7171 - 604-922-2222 - 604-986-1111

Date: Sept 23 2005 \$ 36.00  
From: Westin Bayshore  
To: Airport  
Car No. \_\_\_\_\_ Driver [Signature]

ASK FOR CADILLAC CABS, WHEELCHAIR VANS, STATION WAGONS,  
TOURS, OR OUR 24-HOUR EXPRESS COURIER SERVICE

Returning to North or West Vancouver, call us ... (24 hours)  
Thank-you for riding NORTH SHORE TAXI and Cadillac Cabs



CASH RECEIPT  
**WHITE ROCK SOUTH  
SURREY TAXI LTD.**

UNIT #3 - 17921 - 55TH AVENUE  
SURREY, B.C. V3S 6C4

536-7666 534-5311

G.S.T. # R105671622

Date 23-09-05  
Fare \$ 34.00 G.S.T. Included  
FROM YVR  
TO WESTIN BAY  
DRIVER [Signature] CAB # 42  
"YOUR COMMUNITY CONNECTION"

**EDMONTON AIRPORTS**

GST# R128599776

\*\*\*\*\*  
\*\*\*\*\*

Car park 0000001009 Phone. (780)890-8439  
Fax. (780)890-8329

Receipt no. 0277/0766/00806 23.09.05

015100 pay parking ticket 12,00 \$  
23.09.05 09:58 - 23.09.05 21:39  
Length of stay: 0 Dy. 11 Hr. 41 Min.

total amount 12,00 \$  
accepted total 12,00 \$  
Tax 7,00 % 0,79 \$

Thank you for your patronage!  
Please Come Again!  
\*\* Open 24 hours \*\*  
\*\* Thank you \*\*



# APPLICANT COPY



## Travel Expense Claim Form

(In Canadian Dollars)

(To be used for all Regional and Out of Regional Travel)

(Please Print or Type)

Name Dr. Gerry Pready Employee Number s.17(1)  
 Position Medical Officer of Health Oracle Cost Centre 2010007 71550300036  
 Department Public Health Division Bus. Phone 413-7600  
 Period from October 17, 2005 to October 18, 2005 ~~19-20~~ <sup>Attend MCC meeting</sup>  
Adm. Council for Nat'l Collaborating Centres

Expenses Paid (Please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form.

	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included	DO NOT USE
Accommodation			-		
Meals			17.00	✓	
Registration Fees			-		
Transportation (including parking)			36.00	✓	
Other					
Mileage			24.32	✓	
<b>TOTAL</b>			<b>\$ 77.32</b>		<b>\$</b>
Less Cash Advance			-		
<b>NET</b>			<b>\$ 77.32 w.</b>		

Capital Health  
**RECEIVED**  
 NOV 21 2005  
**ACCOUNTS PAYABLE**

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature [Signature] Date Oct 28/05

Approved by \_\_\_\_\_

Print Name Michelle Lohrey Title Senior VP, Health Services

Signature [Signature] Date Nov 2/05

Print Name \_\_\_\_\_ Title \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**NOTE:** 201.0007. 71550300036. 62414000 = 77.32 (P)

- GST amounts included in the expense claims will be calculated by Accounts Payable.
- Please ensure that the expense claim is properly authorized.
- For all employees on the payroll system, expense cheques will be deposited to employee bank account.
- For physicians, contracted employees and those not paid through the payroll system, expense cheques will be mailed through the internal mail system.
- See the other side of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses also require approval of Chief Operating Officer or Vice President.

# APPLICANT COPY

## EXPENSE CLAIM DETAILS

Date	Particulars	Accommodation \$	Meal \$	Registration \$	Transportation \$	Other \$	Mileage km
Oct 17/05	Taxi mileage				20 <sup>00</sup>		32
Oct 18	mileage Lunch Dinner		17 <sup>00</sup>		16 <sup>00</sup>		32
	<b>Total km</b>						64
	@						<b>\$0.38</b>
<b>TOTALS TO FRONT OF FORM</b>			17 <sup>00</sup>		36 <sup>00</sup>		24.32

### EXPENSE LIMITS

**1. Meal Allowances**

When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:

- Breakfast \$8.00 (if the departure time is earlier or the return time is later than 7:00 a.m.)
- Lunch \$10.00 (if the departure time is earlier or the return time is later than 1:00 p.m.)
- Dinner \$17.00 (if the departure time is earlier or the return time is later than 7:00 p.m.)

For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.

**2. Travel**

- Use of personal automobile – From June 1, 2005, reimbursement at the rate of \$0.38 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.35 for each kilometer there after. Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy. If union contract rates differs from \$0.38 then contract rate must be used.
- Includes all forms of transportation costs, including taxis and buses for local travel.
- Driving to and from work is not considered business travel and cannot be claimed.

**3. Advance**

Travel advance may be requested provided travel expenses are likely to exceed \$500.

**4. Hosting Expenses**

Any "hosting expenses" (including entertainment expenses) have to be approved at a senior level by the Senior Operating Officer, Chief Operating Officer, the Vice President or the President.

APPLICANT COPY

EDMONTON AIRPORTS

GST# R128599776

\*\*\*\*\*  
\*\*\*\*\*

Car park 000001016 phone: (780)891-6439  
Fax: (780)891-8329

Receipt no. 03247 (only 150) 16.10.05

015100 pay parking ticket 16.00 \$  
17.10.05 05.52 - 2.00 24.10  
Length of stay: 1 by 10 hr, 21 Min.

total amount: 16.00 \$  
accepted total 20.00 \$  
change 4.00 \$  
Tax 7.00 % 1.40 \$

Thank you for your patronage.  
Please Come Again!  
\*\* Open 24 hours \*\*  
\*\* Thank you \*\*

Car No.: 285 RECEIPT

G.S.T. No.: \_\_\_\_\_

From: OUT 17/08

To: \_\_\_\_\_

Date: \_\_\_\_\_ Amount \$ 20.00

Signature: A.K.

# APPLICANT COPY



## Travel Expense Claim Form

(In Canadian Dollars)

(To be used for all Regional and Out of Regional Travel)

(Please Print or Type)

S.17(1)

Name G. Prady Employee Number \_\_\_\_\_  
 Position NM Oracle Cost Centre 201000771550300036  
 Department \_\_\_\_\_ Bus. Phone 4137605  
 Period from Oct 24 to Oct 26  
Urban Public Health Network Meeting UPHN Hali Fax

Expenses Paid (Please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form.

	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included	DO NOT USE
Accommodation			361.84	✓	331.70 30.14
Meals			27.00	✓	w
Registration Fees					
Transportation (including parking)			114.00	✓	w
Other					
Mileage			24.32	✓	w
<b>TOTAL</b>			<b>\$ 527.16</b>		<b>\$</b>
Less Cash Advance			-		
<b>NET</b>			<b>\$ 527.16</b>		

RECEIVED

NOV 10 2005

ACCOUNTS PAYABLE

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature [Signature] Date Oct 29/05

Approved by  
 Print Name Michele Lahey Title Sr. VP- Health Services  
 Signature [Signature] Date Oct Nov 2/05  
 Print Name \_\_\_\_\_ Title \_\_\_\_\_  
 Signature \_\_\_\_\_ Date \_\_\_\_\_

**NOTE:** 2010007-71550300036-62414000-527.16

- GST amounts included in the expense claims will be calculated by Accounts Payable.
- Please ensure that the expense claim is properly authorized.
- For all employees on the payroll system, expense cheques will be deposited to employee bank account.
- For physicians, contracted employees and those not paid through the payroll system, expense cheques will be mailed through the internal mail system.
- See the other side of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses also require approval of Chief Operating Officer or Vice President.

APPLICANT COPY

EXPENSE CLAIM DETAILS

Date	Particulars	Accommodation \$	Meal \$	Registration \$	Transportation \$	Other \$	Mileage km
Oct 24/05	Mileage						32
	Lunch		1.00				
	Dinner		17.00				
	Taxi				6.00		
Oct 26/05	<del>Taxi</del> Mileage				32.00		32
	Parley				24.00		
	Hotel	361.84					
<b>Total km</b>							64
<b>@</b>							\$0.38
<b>TOTALS TO FRONT OF FORM</b>		361.84	27.00		114.00		24.32

EXPENSE LIMITS

- Meal Allowances**  
When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:
  - Breakfast \$8.00 (if the departure time is earlier or the return time is later than 7:00 a.m.)
  - Lunch \$10.00 (if the departure time is earlier or the return time is later than 1:00 p.m.)
  - Dinner \$17.00 (if the departure time is earlier or the return time is later than 7:00 p.m.)
For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.
- Travel**
  - Use of personal automobile – From June 1, 2005, reimbursement at the rate of \$0.38 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.35 for each kilometer there after. Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy. If union contract rates differs from \$0.38 then contract rate must be used.
  - Includes all forms of transportation costs, including taxis and buses for local travel.
  - Driving to and from work is not considered business travel and cannot be claimed.
- Advance**  
Travel advance may be requested provided travel expenses are likely to exceed \$500.
- Hosting Expenses**  
Any "hosting expenses" (including entertainment expenses) have to be approved at a senior level by the Senior Operating Officer, Chief Operating Officer, the Vice President or the President.

APPLICANT COPY

EDMONTON AIRPORTS

GST# R128599776

\*\*\*\*\*

\*\*\*\*\*

Car park 0000001009 Phone: (780)890-8439  
Fax: (780)890-8329

Receipt no. 0041 - 570002 - 15.10.05

015100 pay parking ticket 24.00 \$  
24.10.05 06:42 - 26.10.05 15:44  
Length of stay 12 Hr. 12 Min.

total amount 24.00 \$  
accepted total 24.00 \$  
change 1.00 \$  
Tax 1.57 \$

Thank you for your patronage!  
Please Come Again!  
\*\* Open 24 hours \*\*  
\*\* Thank you \*\*

CASINO TAXI

We Appreciate Your Business  
429-6666 • 425-6666

Date 10 26 05  
month day year

Charge to .....

From .....

To .....

Extras. No. of pass only .....

Total Fare \$ 30.00

Signed .....

Car No. 101

SKYLINK TAXI SERVICE

24 Hour Airport Service and Tours Only  
Call Between 6:00a.m. and 10:00p.m. for 24 hour Pickup  
One Hour Notice is Required For Same Day Pickups  
Visa, Amex and [redacted] Accepted  
Corporate Accounts Welcome

TELEPHONE: 902-430-8091

Email: skylinktaxi@hfx.eastlink.ca

DATE: OCT 24 2005  
FROM: AIR-PORT  
TO: ETS  
CAR NUMBER: 149  
DRIVER: RICHARD  
AMOUNT: \$ 60.00  
SIGNATURE: [Signature]

HST# 860889799RT0001

APPLICANT COPY

Mr. Gerry Predy  
Edmonton, AB  
CANADA

S T A T E M E N T      The Westin Nova Scotian, Halifax, 10/25/05

Room Number:      0410      AC      s.17(1)  
Arrival Date:      10/24/05      #  
Departure Date:    10/26/05

DATE	TEXT	ROOM	CHARGES	CREDITS
10/24	Room	0410	155.00	
10/24	HST Tax - Room		23.60	
10/24	HRM Mktg Levy 1.5%		2.32	
10/25	Room		155.00	
10/25	HST Tax - Room		23.60	
10/25	HRM Mktg Levy 1.5%		2.32	
Total			361.84	
Balance			361.84	\$

HST Tax      #89999 4933 RT0001

Cardholder agrees to pay Issuer such total in accordance with Issuer's agreement with Cardholder. I agree that my liability for this bill is not waived and I agree to be held personally liable in the event that the indicated person company or association fails to pay for any part or the full amount of these charges and I shall be responsible for any loss or damage to the premises or its contents.

Signature \_\_\_\_\_

\*\*\*\*\*  
 \*Billing Inquiries? Contact us 902-421-1000\*  
 \* Email us at [guestservices@westin.ns.ca](mailto:guestservices@westin.ns.ca) \*  
 \*\*\*\*\*



# APPLICANT COPY



## Travel Expense Claim Form

(In Canadian Dollars)

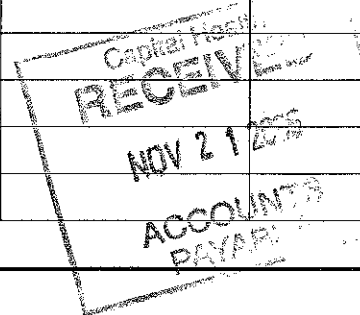
(To be used for all Regional and Out of Regional Travel)

(Please Print or Type)

Name Dr Terry Preddy Employee Number s.17(1)  
 Position Medical Officer of Health Oracle Cost Centre 201 0007 71550300036  
 Department Public Health Division Bus. Phone 413-7600  
 Period from November 4, 2005 to November 4, 2005

Expenses Paid (Please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form.

	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included	DO NOT USE
Accommodation					
Meals					
Registration Fees					
Transportation (including parking)			92.00	✓	
Other					
Mileage			27.36	/	
<b>TOTAL</b>			<b>\$ 119.36</b>	<b>/</b>	<b>\$</b>
Less Cash Advance			-		
<b>NET</b>			<b>\$ 119.36</b>		



The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature [Signature] Date November 7, 2005

Approved by  
 Print Name Michelle Loney Title Senior VP, Health Services

Signature [Signature] Date NOV 09 2005

Print Name \_\_\_\_\_ Title \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

- NOTE:** 201.0007.71550300036.62412000 = 119.36 112.36w 7.00w
- GST amounts included in the expense claims will be calculated by Accounts Payable.
  - Please ensure that the expense claim is properly authorized.
  - For all employees on the payroll system, expense cheques will be deposited to employee bank account.
  - For physicians, contracted employees and those not paid through the payroll system, expense cheques will be mailed through the internal mail system.
  - See the other side of this form for expense claim limits.
  - Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
  - Out of province expenses also require approval of Chief Operating Officer or Vice President.



APPLICANT COPY

09/11/08  
 Date: 09/11/08  
 Chauffeur: ped  
 Unit No.: 29 Amount: 382 G.S.T. INCLUDED  
 G.S.T. No.: 29

EDMONTON AIRPORTS  
 GST# R128599776

\*\*\*\*\*  
 \*\*\*\*\*  
 Car park 00000000000000000000 09-6439  
 09-6439

Receipt no. 00000000000000000000  
 015100 pay tax 00000000000000000000  
 04.11.05 08  
 Length of stay 00000000000000000000

Total amount s.17(1), 17(4)(e.1)

Thank you  
 Please come again  
 Open 24 hours  
 \*\* Thank you \*\*

TRANSACTION RECEIPT =

Bank Checker Group  
 310 Marlborough Road SE  
 Calgary AB T2A 1K7  
 403 249 9900

ACCT TYPE: DEBIT CARD  
 CARD NUMBER

CARD TYPE: DEBIT  
 DATE/TIME: 09/11/08 17:00:00  
 ADDRESS: 310 MARLBOROUGH RD SE  
 CITY/ST/PRV: CALGARY AB T2A 1K7  
 GST# 890616000  
 AMOUNT: 382.00  
 TIP: 0.00  
 TOTAL: 382.00

APPLICANT COPY



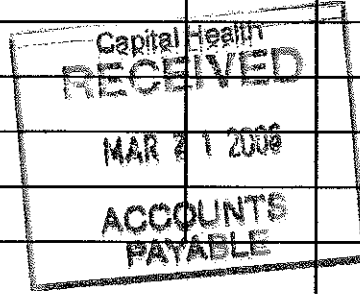
**Travel & Employee Expense Claim Form**  
(In Canadian Dollars)

s.17(1)

Name: <u>Dr. Gerry Dredy</u>	Employee Number:	Union Name:
Position: <u>VP - Public Health &amp; MCH</u>	Department: <u>Public Health Division</u>	
Business Phone: <u>463-7600</u>	Period From: to <u>March 3, 2006</u>	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0007	71550300036	62410000			147.00	<input checked="" type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
Total						147.00	<input checked="" type="checkbox"/>



The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

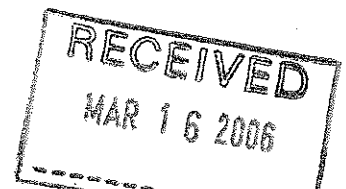
I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: [Signature] Date: March 6/06

Approved By: (Print name) <u>Michele Lohay</u>	Title: <u>Executive VP &amp; COO</u>	Phone #
(Signature) <u>[Signature]</u>	<u>Health Services</u>	Date <u>Mar 10/06</u>
Approved By: (Print name)	Title:	Phone #
(Signature)		Date

NOTE:

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
- GST amounts included in the expense claims will be calculated by Accounts Payable.
- For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
- For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
- See the other side of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses also require approval of Chief Operating Officer or Vice President.





APPLICANT COPY

Driver # \_\_\_\_\_ Car # \_\_\_\_\_  
 To: Eastwell Hqs  
 From: ARJ  
 Date: 3/3/06 Amount: 40.00  
 GST# \_\_\_\_\_

**PRESTIGE**

**CABS**

10135 - 31 Avenue  
Edmonton, Alberta T6N 1C2

**462-4444**

THANK YOU/MERCI

ADMIN: 465-8500

FAX: 462-2722

Date: 3/3/06 Amount/Montant \$ 55.00 Car/Voiture # \_\_\_\_\_

Driver/Chauffeur: \_\_\_\_\_ G.S.T. # \_\_\_\_\_

From/De: \_\_\_\_\_ To/A: \_\_\_\_\_



PLEASE CALL AGAIN  
AU PLAISIR DE VOUS REVOIR

**YELLOW**

ADMIN: 465-8500  
FAX: 462-2722

**CAB**



10135-31 Avenue  
Edmonton, AB T6N 1C2

**462-3456**

THANK YOU/MERCI

Date: 3/3 Amount/Montant \$ 52/ Car/Voiture # 201

Driver/Chauffeur: B GST# \_\_\_\_\_

From/De: 5027-154st To/A: John Lopez





APPLICANT COPY

Travel & Employee Expense Claim Form

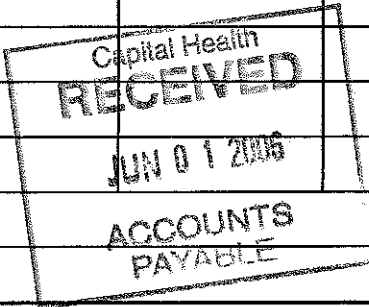
(In Canadian Dollars)

s.17(1)

Name: <i>G. Predy</i>	Employee Number:	Union Name:
Position: <i>VP Public Health</i>	Department:	
Business Phone: <i>413 7600</i>	Period From:	to

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
<i>201</i>	<i>0007</i>	<i>71550300036</i>	<i>6960000</i>			<i>616.61</i>	<input checked="" type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
Total						<i>616.61</i>	<input type="checkbox"/>



The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: *[Signature]* Date: *May 15 2006*

Approved By: (Print name) <i>Michele Lahey</i>	Title: <i>Exec VP COO - Health Services</i>	Phone # <i>407-1671</i>
(Signature) <i>[Signature]</i>		Date <i>May 17/06</i>
Approved By: (Print name)	Title:	Phone #
(Signature)		Date

NOTE:

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
- GST amounts included in the expense claims will be calculated by Accounts Payable.
- For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
- For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
- See the other side of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses also require approval of Chief Operating Officer or Vice President.



# EXPENSE CLAIM DETAILS

Date	Particulars	Accomm. \$	Meal \$	Registration \$	Transportation \$	Other \$	Mileage km
May 8/06	DINNER For Schools Public Health Faculty and Dr John FRANK CIHR DIRECTOR (10 people)		616.61				
<b>Total km</b>							
*(or alternate rate as outlined in Section 2 – Travel below) @							\$0.43*
<b>Totals</b>			616.61				

### EXPENSE LIMITS

- 1. Meal Allowances**  
 When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:  
 Breakfast      \$8.00 (if the departure time is earlier or the return time is later than 7:00 a.m.)  
 Lunch            \$10.00 (if the departure time is earlier or the return time is later than 1:00 p.m.)  
 Dinner            \$17.00 (if the departure time is earlier or the return time is later than 7:00 p.m.)  
 For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.  
 Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.
  
- 2. Travel**
  - Use of personal automobile – From March 1, 2006, reimbursement at the rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
  - Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
  - Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
    1. Monthly travel in excess of 340 kilometers; or
    2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
    3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
  - If union contract rate differs from \$0.43 then contract rate must be used.
  - Includes all forms of transportation costs, including taxis and buses for local travel.
  - Driving to and from work is not considered business travel and cannot be claimed.
  
- 3. Advance**  
 Travel advance may be requested provided travel expenses are likely to exceed \$500.

APPLICANT COPY

MADISON'S BRILL  
10053-Jasper Ave  
Edmonton, Alberta  
780-401-2222

Server: Robert 05/08/2006  
Table 10/1 8:26 PM  
Guests: 10 10053  
Reprint #: 1

Concannon Petit Syrah (3 @3 96.00  
Traditional (2 @5.50) 11.00  
Blackened Salmon Greens 14.00  
Caesar Salad 10.00  
Madisons Greens (2 @10.00) 20.00  
Smoky Butter fish 12.00  
Caesar Salad 10.00  
Artichoke Stuffed Tomato 10.00  
Open Food (6 @32.00) 192.00  
Sundried Tom Smkd Salmon 24.00  
Salsamic Chicken 26.00  
Lemon chicken Salad 13.00  
Roast Pineapple Salmon 29.00  
Soft Drink 2.50  
Choc Frang Molton Cake 11.00  
Cappacino (4 @4.00) 16.00  
Coffee Tea (2 @2.50) 5.00

Sub Total 501.50

BST Exclusive Tax 35.11

Total 536.61

Balance D \$ 536.61

TUITY : 15% 80.00  
: 616.61

THANK YOU  
See Again Soon  
997343794



Capital Health

APPLICANT COPY

Travel & Employee Expense Claim Form

(In Canadian Dollars)

Vancouver

s.17(1)

Name: <i>G. PRBY</i>	Employee Number:	Union Name:
Position: <i>MON</i>	Department: <i>PM Division</i>	
Business Phone: <i>413 7600</i>	Period From: <i>May 28</i> to <i>May 29/06</i>	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
<i>201</i>	<i>0007</i>	<i>71550300036</i>	<i>62414000</i>			<i>650.53</i>	<input checked="" type="checkbox"/>
		<i>609.63 w</i>	<b>ACCRUED</b>				<input type="checkbox"/>
		<i>40.90 n</i>	<i>JUN 06 2006</i>				<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
Total						<i>650.53</i>	<input checked="" type="checkbox"/>

Capital Health  
RECEIVED  
JUN 06 2006  
ACCOUNTS  
PAYABLE

(T)

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: *[Signature]* Date: *May 31/06*

Approved By: <i>Michele Wherry</i> (Print name)	Title: <i>Exec VP &amp; CEO Health Svcs.</i>	Phone # <i>407-1671</i>
(Signature)		Date
Approved By:	Title:	Phone #
(Signature)		Date

NOTE:

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
- GST amounts included in the expense claims will be calculated by Accounts Payable.
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- For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
- See the other side of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses also require approval of Chief Operating Officer or Vice President.

## APPLICANT COPY

### EXPENSE CLAIM DETAILS

Date	Particulars	Accomm. \$	Meal \$	Registration \$	Transportation \$	Other \$	Mileage km
May 28	Taxi				✓ 35.00		
May 28	Lunch		10.00	} 52.00			
	Dinner		17.00				
May 29	Breakfast		8.00				
	Dinner		17.00				
May 29	TAXI				✓ 33.00		
	TAXI				✓ 52.00		
May 28	Hotel	478.53	437.63				
			40.90				
<b>Total km</b>							
*(or alternate rate as outlined in Section 2 – Travel below) @							\$0.43*
<b>Totals</b>		478.53	52.00		120.00		

#### EXPENSE LIMITS

##### 1. Meal Allowances

When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:

- Breakfast \$8.00 (if the departure time is earlier or the return time is later than 7:00 a.m.)
- Lunch \$10.00 (if the departure time is earlier or the return time is later than 1:00 p.m.)
- Dinner \$17.00 (if the departure time is earlier or the return time is later than 7:00 p.m.)

For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.

Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.

##### 2. Travel

- Use of personal automobile – From March 1, 2006, reimbursement at the rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
- Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
- Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
  1. Monthly travel in excess of 340 kilometers; or
  2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
  3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
- If union contract rate differs from \$0.43 then contract rate must be used.
- Includes all forms of transportation costs, including taxis and buses for local travel.
- Driving to and from work is not considered business travel and cannot be claimed.

##### 3. Advance

Travel advance may be requested provided travel expenses are likely to exceed \$500.

APPLICANT COPY



900 WEST GEORGIA STREET  
 VANCOUVER, BC V6C 2W6  
 T 604 684 3131 F 604 662 1929  
 G.S.T. Registration # 86707 3611 RT0002

Room : 1057  
 Folio # : 176181  
 Cashier # : 130  
 Page # : 1 of 1

Gerry Predy  
 CA

Arrival : 05-28-06  
 Departure : 05-29-06

Date	Description	Additional Information	Charges	Credits
05-28-06	Room Charge		409.00	
05-28-06	Room Tax	s.17(1), 17(4)(e.1)	40.90	
05-28-06	Room GST		28.63	
05-29-06	Visa	XX/XX		478.53
<b>Total</b>			<b>478.53</b>	<b>478.53</b>
<b>Balance Due</b>			<b>0.00</b>	

GST Summary

Room	28.63
F&B	0.00
Other	0.00
<b>Total</b>	<b>28.63</b>

Guest signature  
 Signature du client X \_\_\_\_\_  
 For information or reservations, visit us at  
**www.fairmont.com** or call Fairmont Hotels & Resorts from:  
 United States or Canada 1 800 441 1414  
 Pour information et r servations visitez notre web au  
**www.fairmont.com** ou t l phoner au H tels Fairmont de:  
  tats-Unis ou Canada 1 800 441 1414

I agree that my liability for this bill is not waived and I agree to be held personally liable in the event that the indicated person, company or association fails to pay for any part of or the full amount of these charges. Overdue balance subject to a surcharge at the rate of 1.5% per month after one month. (18.00% per annum.)  
 I have accepted delivery of The Globe and Mail. Had I refused, I would have been eligible for a \$.50 (Mon-Fri) and \$1.25 (Sat.) credit to my account. (At participating hotels.)

Je me porte personnellement responsable du r glement total de cette note au cas ou la compagnie, l'association ou son repr sentant d sign  en refuserait le paiement. Les comptes en souffrance sont sujets   un int r t de 1,5% par mois apr s un mois. (18,00% par ann e)  
 J'ai accept  la livraison du journal The Globe and Mail. Si j'avis refus , j'aurais pu obtenir un cr dit   mon compte de 0,50\$ par jour (du Lundi au Vendredi) et de 1,25\$ le Samedi. (Dans les h tels participants.)

**Thank you for choosing to stay with Fairmont Hotels & Resorts**  
**Merci d'avoir choisi les H tels Fairmont**

APPLICANT COPY



CASH RECEIPT

**DELTA SUNSHINE TAXI  
(1972) LTD.  
TSAWASSEN TAXI LTD.**

594-5444 • 594-1111 • 943-1111  
1-866-235-0555

Date: 20 MAY 06

\$ 35.00

From: YVR

To: 4. Vancouver

Driver: [Signature]

Cab No.: #17

"Put a little Sunshine into your day"



**604 681-1111  
604 876-5555**

RECEIVED FROM

DATE

\$ 33.00  
ca

FROM

TO

CAB NO.

DRIVER

AIRPORT SERVICE • 24 Hour Courier • Serving you since 1927  
AT A PAYPHONE? CALL: 1-800-898-TAXI(8294) NO COINS NEEDED  
TTY LINE (hearing impaired) 604 258-4747

GST INCLUDED



10135-31 Avenue  
Edmonton, AB T6N 1C2

ADMIN: 465-8500  
FAX: 462-2722

CAB



**462-3456**

THANK YOU/MERCI

Date: 29/5/06 Amount/Montant \$ 52.00 Car/Voiture # 275

Driver/Chauffeur: [Signature] GST # \_\_\_\_\_

From/De: \_\_\_\_\_ To/A: \_\_\_\_\_



APPLICANT COPY



Travel & Employee Expense Claim Form

(In Canadian Dollars)

s.17(1)

Name: <u>De G Preder</u>	Employee Number:	Union Name:
Position: <u>VP Public Health / n/10H</u>	Department: <u>Public Health</u>	
Business Phone: <u>413-794611</u>	Period From: <u>Nov 3/06</u>	Nov 3/06

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
<u>201</u>	<u>0007</u>	<u>71550300036</u>	<u>62412000</u>			<u>255.42</u>	<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
Total						<u>255.42</u>	<input type="checkbox"/>

Capital Health  
RECEIVED  
NOV 23 2006  
ACCOUNTS  
PAYABLE

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: [Signature] Date: Nov 16 '06

Approved By: (Print name) <u>Michele Lahey</u>	Title: <u>Exec VP &amp; COO-Health Services</u>	Phone # <u>407-1671</u>
(Signature) <u>[Signature]</u>		Date <u>Nov 20/06</u>
Approved By: (Print name)	Title:	Phone #
(Signature)		Date

- NOTE:
- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
  - GST amounts included in the expense claims will be calculated by Accounts Payable.
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  - Out of province expenses also require approval of Chief Operating Officer or Vice President.

## APPLICANT COPY

### EXPENSE CLAIM DETAILS

Date	Particulars	Accomm. \$	Meal \$	Registration \$	Transportation \$	Other \$	Mileage km
	Nov 3 06 - Travel to Calgary - Community Medicine Residency Exams						594
<b>Total km</b>							594
*(or alternate rate as outlined in Section 2 - Travel below) @							\$0.43*
<b>Totals</b>							255.42

**EXPENSE LIMITS**

1. **Meal Allowances**

When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:

  - Breakfast \$8.00 (if the departure time is earlier or the return time is later than 7:00 a.m.)
  - Lunch \$10.00 (if the departure time is earlier or the return time is later than 1:00 p.m.)
  - Dinner \$17.00 (if the departure time is earlier or the return time is later than 7:00 p.m.)

For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.

Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.
2. **Travel**
  - Use of personal automobile – From March 1, 2006, reimbursement at the rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
  - Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
  - Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
    1. Monthly travel in excess of 340 kilometers; or
    2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
    3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
  - If union contract rate differs from \$0.43 then contract rate must be used.
  - Includes all forms of transportation costs, including taxis and buses for local travel.
  - Driving to and from work is not considered business travel and cannot be claimed.
3. **Advance**

Travel advance may be requested provided travel expenses are likely to exceed \$500.



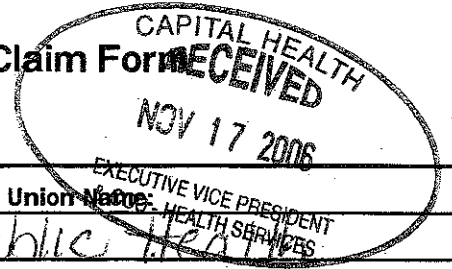
APPLICANT COPY



Travel & Employee Expense Claim Form

(In Canadian Dollars)

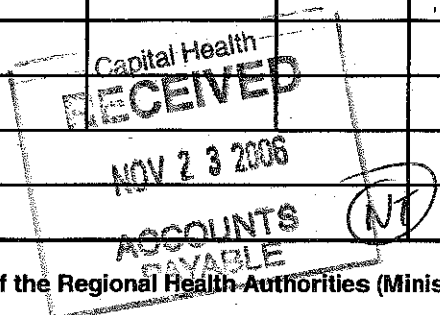
s.17(1)



Name: <u>DP G. Prady</u>	Employee Number:	Union Name: <u>HEALTH SERVICES</u>
Position: <u>VP Public Health MCH</u>	Department: <u>Public Health</u>	
Business Phone: <u>413-7946</u>	Period From:	to

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
<u>201</u>	<u>0007</u>	<u>71550300036</u>	<u>66010000</u>			<u>1260.00</u>	<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
Total							<input type="checkbox"/>



The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: [Signature] Date: NOV 16 06

Approved By: <u>Michele Lahey</u> (Print name)	Title: <u>Exec VP &amp; COO Health Services</u>	Phone # <u>407-1671</u>
(Signature) <u>Michele Lahey</u>		Date <u>NOV 20/06</u>
Approved By:	Title:	Phone #
(Signature)		Date

- NOTE:**
- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
  - GST amounts included in the expense claims will be calculated by Accounts Payable.
  - For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
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  - Out of province expenses also require approval of Chief Operating Officer or Vice President.

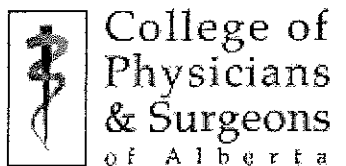
APPLICANT GORY  
EXPENSE CLAIM DETAILS

Date	Particulars	Accomm. \$	Meal \$	Registration \$	Transportation \$	Other \$	Mileage km
NOV 10/06	College of Physicians & Surgeons Licence Renewal					License fee 1260.00	
						1260.00	
						<b>Total km</b>	
						<b>*(or alternate rate as outlined in Section 2 – Travel below) @</b>	<b>\$0.43*</b>
<b>Totals</b>						1260.00	

**EXPENSE LIMITS**

- 1. **Meal Allowances**  
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  - Dinner \$17.00 (if the departure time is earlier or the return time is later than 7:00 p.m.)For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.  
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  - Use of personal automobile – From March 1, 2006, reimbursement at the rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer thereafter (except where collective agreement specifies otherwise).
  - Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
  - Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
    - 1. Monthly travel in excess of 340 kilometers; or
    - 2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
    - 3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
  - If union contract rate differs from \$0.43 then contract rate must be used.
  - Includes all forms of transportation costs, including taxis and buses for local travel.
  - Driving to and from work is not considered business travel and cannot be claimed.
- 3. **Advance**  
Travel advance may be requested provided travel expenses are likely to exceed \$500.

## APPLICANT COPY



# 2007 Licence Renewal



## CONFIRMATION & PAYMENT OPTIONS

**Thank you for using our online Registration Information Form!**

**Your registration information and payment have been successfully submitted.**

**Details of your credit card transaction will follow this message. This receipt confirms that your Registration Information Form has been received by the CPSA. If you provided a valid e-mail address on the payment page, you will receive an e-mail containing these details.**

**Please contact the Registration Department of the CPSA if you have any questions or concerns about your online registration experience. Contact us at 1-800-320-8624 (toll free), at 780-423-4764 (Edmonton local), or contact us by e-mail at [annualbilling@cpsa.ab.ca](mailto:annualbilling@cpsa.ab.ca).**

### Receipt:

Payment Authorization Results	
Shopping cart status:	PAID
Credit card:	Gerald N. Predy / s.17(1), 17(4)(e.1)
Amount:	1,260.00
Transaction time:	10-Nov-2006 07:23:04
Reference:	018337 / 090955 / 4285-4-0:660780520011570040:027:01

Shopping Cart Details						
Item	Quantity	Price	Taxes	Total	Ship?	
2007 Licencing Fee	1 @	1,260.00	1,260.00	0.00	1,260.00	N
<b>Totals:</b>		<b>1,260.00</b>	<b>0.00</b>	<b>1,260.00</b>		

**To view a printable/saveable version of your Registration Information Form, please click [here](#) complete with all of the information you have entered online, please click [here](#).**

**Please print this page as a confirmation of your transaction.**

[Click here to return to the CPSA web site.](#)

APPLICANT COPY



**Travel & Employee Expense Claim Form**  
(In Canadian Dollars) s.17(1)

Name: <u>Dr. G. Prady</u>	Employee Number:	Union Name:
Position: <u>VP Public Health Mgt</u>	Department: <u>Public Health</u>	
Business Phone: <u>413.7600</u>	Period From: <u>Oct 16</u> to <u>Oct 18/06</u>	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

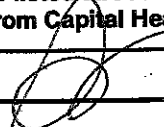
Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
<u>201</u>	<u>0007</u>	<u>715503000 36</u>	<u>62414000</u>			<u>551.70</u>	<input checked="" type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
Total						<u>551.70</u>	<input checked="" type="checkbox"/>

Capital Health  
**RECEIVED**  
NOV 01 2006  
ACCOUNTS  
PAYABLE

532.94  
63.76

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature:  Date: Oct 20 06

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: <u>Michele Lacey</u> (Print name)	Title: <u>Exec VP COO - Health Serv</u>	Phone # <u>407-1671</u>
(Signature)		Date
Approved By:	Title:	Phone #
(Print name)		Date
(Signature)		

**NOTE:**

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
- GST amounts included in the expense claims will be calculated by Accounts Payable.
- Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
- For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
- For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
- See page 2 of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

APPLICANT COPY

**DELTA**

CHELSEA

DOWNTOWN TORONTO

33 Gerrard Street West

Toronto, Ontario M5G 1Z4

Telephone: (416) 595-1975 Fax: (416) 581-8934

Billing Direct: 1-800-268-9070

Jerry Predy

CA

Arrival 10/16/06  
 Departure 10/18/06  
 Room No. 0707  
 Folio No. 340367  
 Cashier 27  
 Page No. 1 of 1

Group Code GLBUPH

Date	Description	Debit	Credit
10/16/06	Room Charge	139.00	
10/16/06	Room GST	8.34	
10/16/06	Room PST	6.95	
10/16/06	DMF	3.93	
10/16/06	Room DMF GST	0.24	
10/17/06	Room Charge	139.00	
10/17/06	Room GST	8.34	
10/17/06	Room PST	6.95	
10/17/06	DMF	3.93	
10/17/06	Room DMF GST	0.24	
10/18/06	Visa		316.92
		s.17(1), 17(4)(e.1)	

**GST Summary:**

Room 16.68  
 F&B 0.00  
 Other 0.48  
 Total 17.16

G.S.T. Registration #887925881

Balance 0.00

Guest Signature

I agree that my liability for this bill is not waived and agree to be held personally liable in the event that the indicated person, company or association fails to pay for any part or the full amount of these charges. Delta agrees to transmit credit to card issuer for payment. Merchandise/or services purchased on this credit card shall not be resold for cash refund. I have accepted delivery of The Globe and Mail. Had I refused, I would have been eligible for a \$.50 (Mon.-Fri.) and \$1.25 (Sat.) credit to my account. (At participating hotels.)

**EXPENSE CLAIM DETAILS**

*for approval*

Recommended Coding							
<ul style="list-style-type: none"> <li>Local Travel – Staff - 62410000</li> <li>Staff Local Travel – Taxi – 62410001</li> <li>Staff Travel – UNA – 62410002</li> <li>Staff Provincial Travel – 62412000 (all expenses)</li> <li>Staff Out of Province Travel – 62414000 (all expenses)</li> </ul>				<ul style="list-style-type: none"> <li>Catering – 69600000</li> <li>Meals - 62410000</li> <li>Mileage – 62410000</li> <li>Course Registration &amp; Materials – 61030000</li> </ul>			
Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
Oct 16	UPIN meeting @ [unclear] travel to airport						38
Oct 16	Taxi				✓ 65.00	w	
Oct 18	Taxi				✓ 60.00		
Oct 18	Hotel	316.92					
Oct 18	Airport Party				✓ 38.70	w	
Oct 18	home to airport						38
Oct 16	Dinner		19.20				
Oct 17	Dinner		19.20				
<b>Total km</b>							76
<b>Rate as outlined in Section 2 – Travel below @</b>							.43
<b>Totals</b>		316.92	38.40		163.70		3268

**EXPENSE LIMITS**

- Meal Allowances** ~~28~~ 303.16 w 13.76 w

When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:

  - Breakfast \$8.50 (if the departure time is earlier or the return time is later than 7:30 a.m.)
  - Lunch \$10.75 (if the departure time is earlier or the return time is later than 1:00 p.m.)
  - Dinner \$19.20 (if the departure time is earlier or the return time is later than 6:30 p.m.)

For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.

Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.
- Travel**

  - Use of personal automobile – From March 1, 2006, reimbursement at the general rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
  - Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
  - Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
    - Monthly travel in excess of 340 kilometers; or
    - Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
    - Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
  - If union contract rate differs from \$0.43 then contract rate must be used.
  - Includes all forms of transportation costs, including taxis and buses for local travel.
  - Driving to and from work is not considered business travel and cannot be claimed.
- Advance**

Travel advance may be requested provided travel expenses are likely to exceed \$500.



Donna  
The black one is  
actually a receipt.  
The amount is in  
the bottom right  
hand corner  
\$60.00

Laura

**AEROPORT**  
TAXI & LIMOUSINE SERVICE

24 HOUR SERVICE

MasterCard VISA

39 Years of Service

FREE WAKE-UPS WITH RESERVATION

SPECIAL FLAT RATES TO & FROM AIRPORT CORPORATE & COMMERCIAL ACCOUNTS WELCOME CREDIT CARDS ACCEPTED [www.aeropotaxi.com](http://www.aeropotaxi.com)

EDMONTON AIRPORTS  
GST# R128598776

\*\*\*\*\*  
\*\*\*\*\*

Call 1-800-465-3434 or 780-480-8439  
1-800-465-3434

Rec 16.10.06 16:48:30 16.10.06

015100 pay parking ticket 38,70 \$  
16.10.06 08:30 - 18.10.06 16:48  
Length of stay: 2 Dy 8 Hr. 18 Min.

total amount	38,70 \$
accepted total	50,00 \$
change	11,30 \$
G.S.T. 6.00 %	2,19 \$

Thank you for your patronage!  
Please Come Again!  
\*\* Open 24 hours \*\*  
\*\* Thank you \*\*

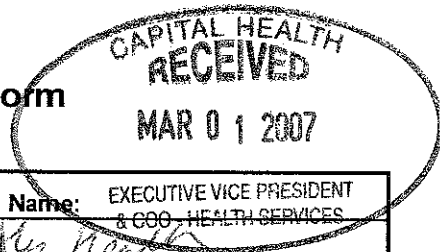


**Capital Health**  
EDMONTON AREA

APPLICANT COPY

**Travel & Employee Expense Claim Form**

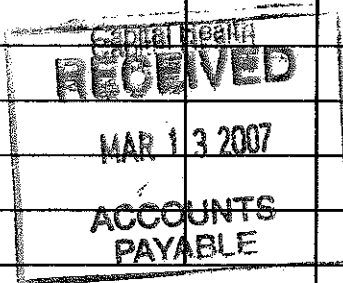
(In Canadian Dollars) s.17(1)



Name: <u>G. PREVY</u>	Employee Number:	Union Name: EXECUTIVE VICE PRESIDENT & COO - HEALTH SERVICES
Position:	Department: <u>Public Health</u>	
Business Phone: <u>413 7600</u>	Period From:	to

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
<u>201</u>	<u>0001</u>	<u>715503 00036</u>	<u>66020000</u>			<u>1260.00</u>	<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
Total						<u>1260.00</u>	<input type="checkbox"/>



The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: [Signature] Date: Feb 28 2007

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: <u>Nichelle Lahey</u> (Print name)	Title: <u>Exec VP + COO Health Services</u>	Phone #
(Signature) <u>Nichelle Lahey</u>		Date <u>MAR 01 2007</u>
Approved By:	Title:	Phone #
(Signature)		Date

- NOTE:
- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
  - GST amounts included in the expense claims will be calculated by Accounts Payable.
  - Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
  - For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
  - For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
  - See page 2 of this form for expense claim limits.
  - Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
  - Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP



# APPLICANT COPY

## EXPENSE CLAIM DETAILS

### Recommended Coding

- Local Travel – Staff - 62410000
- Staff Local Travel – Taxi – 62410001
- Staff Travel – UNA – 62410002
- Staff Provincial Travel – 62412000 (all expenses)
- Staff Out of Province Travel – 62414000 (all expenses)
- Catering – 69600000
- Meals - 62410000
- Mileage – 62410000
- Course Registration & Materials – 61030000

Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
3/1/07						Medgrocery Jusaid	
						1260.00	
<b>Total km</b>							
<b>Rate as outlined in Section 2 – Travel below @</b>							
<b>Totals</b>							1260.00

### EXPENSE LIMITS

1. **Meal Allowances**  
 When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:
  - Breakfast \$10.00 (if the departure time is earlier or the return time is later than 7:30 a.m.)
  - Lunch \$15.00 (if the departure time is earlier or the return time is later than 1:00 p.m.)
  - Dinner \$25.00 (if the departure time is earlier or the return time is later than 6:30 p.m.)
 For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.  
 Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.
2. **Travel**
  - Use of personal automobile – From March 1, 2006, reimbursement at the general rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
  - Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
  - Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
    1. Monthly travel in excess of 340 kilometers; or
    2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
    3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
  - If union contract rate differs from \$0.43 then contract rate must be used.
  - Includes all forms of transportation costs, including taxis and buses for local travel.
  - Driving to and from work is not considered business travel and cannot be claimed.
3. **Advance**  
 Travel advance may be requested provided travel expenses are likely to exceed \$500.

APPLICANT COPY

INVOICE 2007



THE CANADIAN L'ASSOCIATION  
 MEDICAL CANADIENNE  
 PROTECTIVE DE PROTECTION  
 ASSOCIATION MÉDICALE

DR GERALD PREDY  
 300-10216 124 ST NW  
 EDMONTON AB T5N 4A3

DATE: Nov. 1, 2006  
**MEMBER NUMBER:** s.17(1)

**YOUR MEMBERSHIP FEES FOR THE PERIOD 01/01/2007 TO 12/31/2007.**

*Based on the protection information on the accompanying Membership Update.*

REFERENCE	DATE	FEES	TAX	TOTAL
0010394044	Jan-2007	\$ 105.00	\$ 0.00	\$ 105.00
0010394044	Feb-2007	\$ 105.00	\$ 0.00	\$ 105.00
0010394044	Mar-2007	\$ 105.00	\$ 0.00	\$ 105.00
0010394044	Apr-2007	\$ 105.00	\$ 0.00	\$ 105.00
0010394044	May-2007	\$ 105.00	\$ 0.00	\$ 105.00
0010394044	Jun-2007	\$ 105.00	\$ 0.00	\$ 105.00
0010394044	Jul-2007	\$ 105.00	\$ 0.00	\$ 105.00
0010394044	Aug-2007	\$ 105.00	\$ 0.00	\$ 105.00
0010394044	Sep-2007	\$ 105.00	\$ 0.00	\$ 105.00
0010394044	Oct-2007	\$ 105.00	\$ 0.00	\$ 105.00
0010394044	Nov-2007	\$ 105.00	\$ 0.00	\$ 105.00
0010394044	Dec-2007	\$ 105.00	\$ 0.00	\$ 105.00
		<b>\$ 1,260.00</b>	<b>\$ 0.00</b>	<b>\$ 1,260.00</b>

**TOTAL 2007 FEE: \$ 1,260.00**

**YOUR PAYMENT METHOD IS: Annual Direct Debit.**

Unless your banking information has changed, you do not need to send a remittance stub or void cheque. Please see reverse for instructions and other payment methods.



THE CANADIAN L'ASSOCIATION  
 MEDICAL CANADIENNE  
 PROTECTIVE DE PROTECTION  
 ASSOCIATION MÉDICALE

**DIRECT DEBIT PLAN**

DR GERALD PREDY  
 300-10216 124 ST NW  
 EDMONTON AB T5N 4A3

For Office Use Only:

**MEMBER NUMBER:** s.17(1) **TOTAL FEE: \$ 1,260.00**

0010394044

DD 1DD

# APPLICANT COPY

Jan 31, 2007 CMPA / ACPM AP

1,260.00

Non-Responsive

▼ Date	Description	Debit	Credit
Top	<a href="#">About This Statement - Feb 28, 2007</a> <a href="#">Customize Account Activity</a>		

[Download](#) to:

All transactions to the close of the previous BUSINESS day will be downloaded.  
Information about supported versions of software for downloads.

F

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(Server ID: 47x : 11)



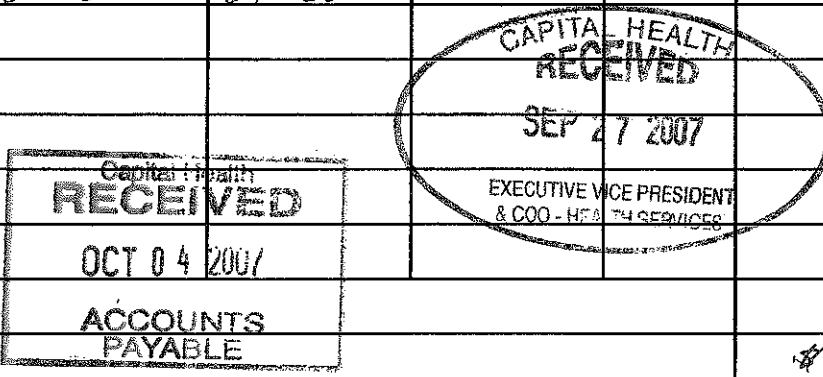
**Travel & Employee Expense Claim Form**

(In Canadian Dollars) s.17(1)

Name: <i>Dr. G Predy</i>	Employee Number: _____	Union Name: _____
Position: <i>UP Public Health, MOH</i>	Department: <i>Public Health</i>	
Business Phone: <i>413-7946</i>	Period From: <i>Sept 15 to Sept 19, 2007</i>	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
<i>201</i>	<i>0007</i>	<i>715503000 36</i>	<i>61530030</i>				<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
Total						<i>\$ 25.00</i>	<input type="checkbox"/>



The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: *[Signature]* Date: *Sept 26 2007*

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: (Print name) <i>Michele Lahoy</i>	Title: <i>Exec. VP + COO Health Services</i>	Phone #
(Signature) <i>[Signature]</i>		Date <i>Sept 28/2007</i>
Approved By: (Print name) <i>Michele Lahoy</i>	Title: _____	Phone #
(Signature) <i>[Signature]</i>		Date

- NOTE:**
- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
  - GST amounts included in the expense claims will be calculated by Accounts Payable.
  - Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
  - For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
  - For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
  - See page 2 of this form for expense claim limits.
  - Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
  - Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

**APPLICANT COPY**  
**EXPENSE CLAIM DETAILS**

Recommended Coding							
<ul style="list-style-type: none"> <li>61530030 – Workshop Fees &amp; Materials</li> <li>61520020 – Academic Course Fees &amp; Materials</li> <li>61540040 – Conference Fees &amp; Materials</li> <li>62300000 – Meals</li> <li>62320000 – Staff Local Travel – Client Related</li> <li>62310000 – Staff Local Travel – Non-Client Related</li> <li>62320000 – Staff Local Travel – Taxi – Client Related</li> </ul>				<ul style="list-style-type: none"> <li>62310000 – Staff Local Travel – Taxi – Non-Client Related</li> <li>62320000 – Staff Travel – UNA – Client Related</li> <li>62310000 – Staff Travel – UNA – Non-Client Related</li> <li>62312000 – Staff Provincial Travel – Non-Client Related</li> <li>62314000 – Staff Out of Province Travel – Non-Client Related</li> <li>Catering – 69600000</li> </ul>			
Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
Sept 16	Registration fee for pre-conference session at CHHA					75.00	
<b>Total km</b>							
<b>Rate as outlined in Section 2 – Travel below @</b>							
<b>Totals</b>							

**EXPENSE LIMITS**

- Meal Allowances**  
 When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:  
 Breakfast      \$10.00 (if the departure time is earlier or the return time is later than 7:30 a.m.)  
 Lunch            \$15.00 (if the departure time is earlier or the return time is later than 1:00 p.m.)  
 Dinner           \$25.00 (if the departure time is earlier or the return time is later than 6:30 p.m.)  
 For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.  
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- Travel**
  - Use of personal automobile – From March 1, 2006, reimbursement at the general rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
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    - Monthly travel in excess of 340 kilometers; or
    - Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
    - Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
  - If union contract rate differs from \$0.43 then contract rate must be used.
  - Includes all forms of transportation costs, including taxis and buses for local travel.
  - Driving to and from work is not considered business travel and cannot be claimed.
- Advance**  
 Travel advance may be requested provided travel expenses are likely to exceed \$500.

APPLICANT COPY



Canadian Public Health Association

Association canadienne de santé publique

**RECEIPT**

Suite 400  
1565 Carling Avenue  
Ottawa, ON K1Z 8R1  
Fax: 613-725-9826

Date	Receipt No.
09-25-2007	A006952

Payer:

Gerry N Predy  
#300 10216 - 124 Street  
Edmonton, AB, T5N 4A3 Canada

Inv No.	Description	Total Fees	Tax	Applied Amount
A0007380	Registration for Dr Gerry Predy for: CPHA 2007 Annual Conference and Public Health Geomatics Conference - NSSCM Pre-conference Session	75.00	0.00	75.00

	<b>Total Fees w/Tax</b>	75.00
Visa:	<b>Total Paid</b>	75.00
s.17(1), 17(4)(e.1)	<b>Total Applied</b>	75.00
	<b>Unapplied Balance</b>	0.00

Thank you for your payment received on 09-25-2007.

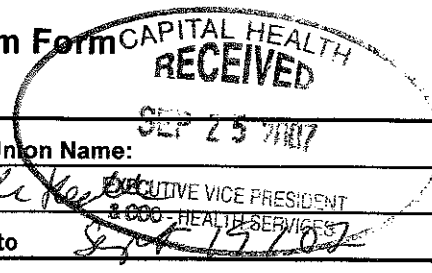


**Capital Health**  
EDMONTON AREA

APPLICANT COPY

**Travel & Employee Expense Claim Form**

(In Canadian Dollars) s.17(1)



Name: <i>Gerry Pray</i>	Employee Number:	Union Name: <i>SEP 25 2007</i>
Position: <i>Man</i>	Department: <i>Public Health</i>	<i>EXECUTIVE VICE PRESIDENT</i>
Business Phone: <i>4137600</i>	Period From: <i>Sept 15</i>	to: <i>Sept 15 2007</i>

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
<i>201</i>	<i>0007</i>	<i>71550300060</i>	<i>61512040</i>			<i>1206.14</i>	<input checked="" type="checkbox"/>
			<i>62314</i>				<input type="checkbox"/>
			<i>Capital Health RECEIVED</i>	<i>ACCRUED</i>			<input type="checkbox"/>
			<i>OCT 04 2007</i>	<i>OCT 01 2007</i>			<input type="checkbox"/>
			<i>ACCOUNTS PAYABLE</i>	<i>1106.49w</i>			<input type="checkbox"/>
				<i>39.65w</i>			<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
Total						<i>1206.14</i>	<input type="checkbox"/>

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: <i>[Signature]</i>	Date: <i>Sept 21/07</i>
--	-------------------------

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: <i>[Signature]</i> (Print name)	Title:	Phone #
(Signature)		Date: <i>SEP 25 2007</i>
Approved By:	Title:	Phone #
(Signature)		Date:

NOTE:

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
- GST amounts included in the expense claims will be calculated by Accounts Payable.
- Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
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- For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
- See page 2 of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

**EXPENSE CLAIM FORM**

**Recommended Coding**

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>• 61530030 – Workshop Fees &amp; Materials</li> <li>• 61520020 – Academic Course Fees &amp; Materials</li> <li>• 61540040 – Conference Fees &amp; Materials</li> <li>• 62300000 – Meals</li> <li>• 62320000 – Staff Local Travel – Client Related</li> <li>• 62310000 – Staff Local Travel – Non-Client Related</li> <li>• 62320000 – Staff Local Travel – Taxi – Client Related</li> </ul> | <ul style="list-style-type: none"> <li>• 62310000 – Staff Local Travel – Taxi – Non-Client Related</li> <li>• 62320000 – Staff Travel – UNA – Client Related</li> <li>• 62310000 – Staff Travel – UNA – Non-Client Related</li> <li>• 62312000 – Staff Provincial Travel – Non-Client Related</li> <li>• 62314000 – Staff Out of Province Travel – Non-Client Related</li> <li>• Catering – 69600000</li> </ul> |
|--|---|

Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
Sept 15/07	From Ottawa to						
Sept 18	to airport						40 km
	taxi in Ottawa			✓	35.00 w		
	taxi in Ottawa			✓	14.00 w		
	from airport						40 km
	Hotel	912.74					
	Meals 4B		40.00				
	3L		45.00				
	5D		125.00				
<b>Total km</b>							80 km
<b>Rate as outlined in Section 2 – Travel below @</b>							.43
<b>Totals</b>		912.74	210.00		49.00		34.00

**EXPENSE LIMITS**

**1. Meal Allowances**

When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:

- Breakfast \$10.00 (if the departure time is earlier or the return time is later than 7:30 a.m.)
- Lunch \$15.00 (if the departure time is earlier or the return time is later than 1:00 p.m.)
- Dinner \$25.00 (if the departure time is earlier or the return time is later than 6:30 p.m.)

For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.

Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.

**2. Travel**

- Use of personal automobile – From March 1, 2006, reimbursement at the general rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
- Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
- Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
  1. Monthly travel in excess of 340 kilometers; or
  2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
  3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
- If union contract rate differs from \$0.43 then contract rate must be used.
- Includes all forms of transportation costs, including taxis and buses for local travel.
- Driving to and from work is not considered business travel and cannot be claimed.

**3. Advance**

Travel advance may be requested provided travel expenses are likely to exceed \$500.



# APPLICANT COPY

the westin ottawa  
 11 colonel by drive ottawa, ontario k1n 9h4 canada  
 phone 613.560.7000 fax 613.560.7359  
 westin.com/ottawa

guest <b>Gerald Predy</b>  300 10216 124 St Edmonton, AB T5N 4A3 Canada  GCI13G	room/chambre rate/tarif # pers /n° pers folio/dossier page arrive/arrivee depart/depart payment/paiement	1328 199.00 2 233470      EX-A 1 15-SEP-07 19-SEP-07 VI	travel agent/charge to agent de voyage/débité à
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15-SEP-07	RT1328	Room	199.00
15-SEP-07	RT1328	G.S.T. Room 6%	11.94
15-SEP-07	RT1328	P.S.T. Room 5%	9.95
15-SEP-07	RT1328	DMF Fee 2.83%	5.63
15-SEP-07	RT1328	GST On DMF 6%	0.34
16-SEP-07	RT1328	Room	199.00
16-SEP-07	RT1328	G.S.T. Room 6%	11.94
16-SEP-07	RT1328	P.S.T. Room 5%	9.95
16-SEP-07	RT1328	DMF Fee 2.83%	5.63
16-SEP-07	RT1328	GST On DMF 6%	0.34
17-SEP-07	RT1328	Room	199.00
17-SEP-07	RT1328	G.S.T. Room 6%	11.94
17-SEP-07	RT1328	P.S.T. Room 5%	9.95
17-SEP-07	RT1328	DMF Fee 2.83%	5.63
17-SEP-07	RT1328	GST On DMF 6%	0.34
17-SEP-07	in fax	Fax Revenue	5.00
17-SEP-07	in fax	Tax GST 6%	0.30
18-SEP-07	RT1328	Room	199.00
18-SEP-07	RT1328	G.S.T. Room 6%	11.94
18-SEP-07	RT1328	P.S.T. Room 5%	9.95
18-SEP-07	RT1328	DMF Fee 2.83%	5.63
18-SEP-07	RT1328	GST On DMF 6%	0.34
19-SEP-07	VI	Visa	912.74-
<b>Total Charges</b>			<b>912.74</b>
<b>Total Credits</b>			<b>912.74-</b>
<b>Balance Due</b>			<b>0.00</b>

873.09w  
 39.65w

\*\* continued on the next page \*\*

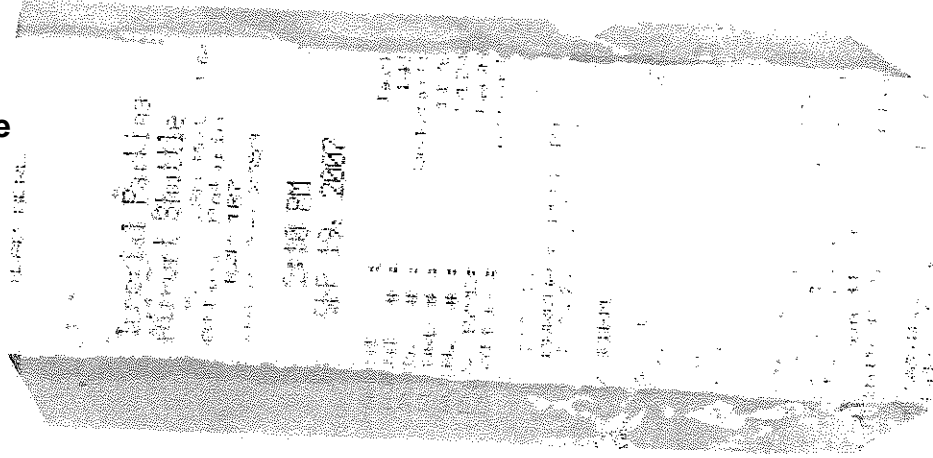
I agree to remain personally liable for the payment of this account if the corporation or other third party billed fails to pay part or all of these charges.  
 J'assume l'entière responsabilité du paiement du présent compte si l'entreprise ou un autre tiers ne paie pas une partie ou la totalité des frais

signature \_\_\_\_\_

Gerald Predy  
 FOLIO 233470 15-SEP-07

APPLICANT COPY

Best Copy Possible



RECEIPT / REÇU	
Amount/Montant:	35.90
From/De:	AIRPORT
To/à:	
Taxi #:	759
Driver/Chauffeur:	<i>[Signature]</i>
<i>Thank you / Merci</i>	

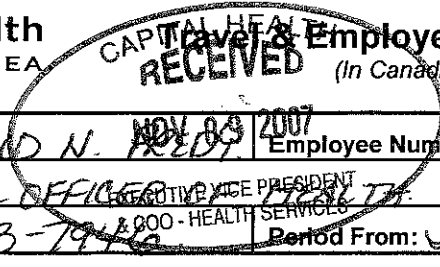


**Capital Health**  
EDMONTON AREA

APPLICANT COPY

**Travel & Employee Expense Claim Form**  
(In Canadian Dollars) s.17(1)

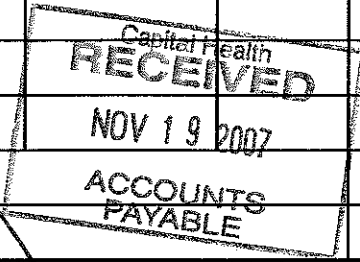
Pd  
EXP Repat  
26 Nov 2007.1007



Name: <u>DR. GERRARD N. REDY</u>	Employee Number:	Union Name:
Position: <u>MEDICAL OFFICER (AGGRESSIVE VICE PRESIDENT HEALTH)</u>	Department: <u>OFFICE OF THE M.O.H.</u>	
Business Phone: <u>413-7916</u>	Period From: <u>Jan, 2008</u> to <u>Dec, 2008.</u>	

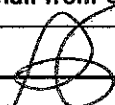
Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0007	71550300036	66010000			1500. <sup>00</sup>	<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
Total						1500. <sup>00</sup>	<input type="checkbox"/>




The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature:  Date: NOV 7/07

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: <u>Michele Whelan</u> (Print name)	Title: <u>Exec VP &amp; COO Health</u>	Phone # <u>407-1671</u>
(Signature)	<u>Berucci</u>	Date <u>Nov 13/07</u>
Approved By:	Title:	Phone #
(Signature)		Date

- NOTE:**
- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
  - GST amounts included in the expense claims will be calculated by Accounts Payable.
  - Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
  - For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
  - For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
  - See page 2 of this form for expense claim limits.
  - Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
  - Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

# APPLICANT COPY EXPENSE CLAIM DETAILS

Recommended Coding							
<ul style="list-style-type: none"> <li>61530030 – Workshop Fees &amp; Materials</li> <li>61520020 – Academic Course Fees &amp; Materials</li> <li>61540040 – Conference Fees &amp; Materials</li> <li>62300000 – Meals</li> <li>62320000 – Staff Local Travel – Client Related</li> <li>62310000 – Staff Local Travel – Non-Client Related</li> <li>62320000 – Staff Local Travel – Taxi – Client Related</li> </ul>				<ul style="list-style-type: none"> <li>62310000 – Staff Local Travel – Taxi – Non-Client Related</li> <li>62320000 – Staff Travel – UNA – Client Related</li> <li>62310000 – Staff Travel – UNA – Non-Client Related</li> <li>62312000 – Staff Provincial Travel – Non-Client Related</li> <li>62314000 – Staff Out of Province Travel – Non-Client Related</li> <li>Catering – 69600000</li> </ul>			
Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
Nov 1/07	2008 Licensing Fee.						
<b>Total km</b>							
<b>Rate as outlined in Section 2 – Travel below @</b>							
<b>Totals</b>							

**EXPENSE LIMITS**

**1. Meal Allowances**

When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:

- Breakfast     \$10.00 (if the departure time is earlier or the return time is later than 7:30 a.m.)
- Lunch         \$15.00 (if the departure time is earlier or the return time is later than 1:00 p.m.)
- Dinner        \$25.00 (if the departure time is earlier or the return time is later than 6:30 p.m.)

For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.

Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.

**2. Travel**

- Use of personal automobile – From March 1, 2006, reimbursement at the general rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
- Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
- Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
  1. Monthly travel in excess of 340 kilometers; or
  2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
  3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
- If union contract rate differs from \$0.43 then contract rate must be used.
- Includes all forms of transportation costs, including taxis and buses for local travel.
- Driving to and from work is not considered business travel and cannot be claimed.

**3. Advance**

Travel advance may be requested provided travel expenses are likely to exceed \$500.

## APPLICANT COPY

**Predy, Gerry Dr.**

**From:** CPSA Registration Department [annualbilling@cpsa.ab.ca]  
**Sent:** Thursday, November 01, 2007 4:01 PM  
**To:** Predy, Gerry Dr.  
**Subject:** CPSA 2008 Licencing Fees Confirmation

Thank you for using our online Registration Information Form!

Your registration information and payment have been successfully submitted.

*Medical  
License*

Details of your credit card transaction will follow this message. This receipt confirms that your Registration Information Form has been received by the CPSA.

To view a printable/saveable version of your Registration Information Form, complete with all of the information you have entered online, please click [here](#).

Please contact the Registration Department of the CPSA if you have any questions or concerns about your online registration experience. Contact us at 1-800-561-3899 (toll free), at 780-423-4764 (Edmonton local), or contact us via e-mail at [annualbilling@cpsa.ab.ca](mailto:annualbilling@cpsa.ab.ca).

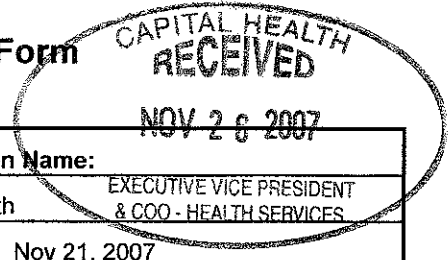
Payment Authorization Results	
Shopping cart status:	PAID
Credit card:	Gerald N. Predy / s.17(1), 17(4)(e.1)
Amount:	\$ 1,500.00
Transaction time:	01-Nov-2007 16:01:28
Reference:	021955 / 032563 / 8457-0_1:660780520013880120:027:01

Shopping Cart Details					
Item	Quantity	Price	Taxes	Total	Ship?
2008 Licencing Fee	1 @ 1,500.00	1,500.00	0.00	1,500.00	N
Totals:		1,500.00	0.00	1,500.00	

Please print this as a confirmation of your transaction.

**Travel & Employee Expense Claim Form**

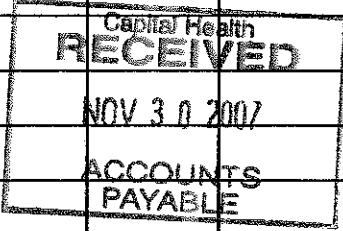
(In Canadian Dollars) s.17(1)



Name: Gerry Predy	Employee Number:	Union Name:
Position: VP Public Health/Medical Officer of Health	Department: Public Health	
Business Phone: 413-5070	Period From: Nov 21	to Nov 21, 2007

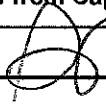
Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0007	71550300036	61540040	\$495.00	1.02	504.90	<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance						504.90 (AM)	<input type="checkbox"/>
Total						\$495.00 (US)	<input type="checkbox"/>



The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature:  Date: 2/11/07

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: MICHELE LAANEY (Print name)	Title: EXEC VPT COO - HEALTH SERVICES	Phone #: 407-1671
(Signature)		Date: NOV 26 2007
Approved By:	Title:	Phone #:
(Signature)		Date:

- NOTE:
- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
  - GST amounts included in the expense claims will be calculated by Accounts Payable.
  - Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
  - For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
  - For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
  - See page 2 of this form for expense claim limits.
  - Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
  - Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

**APPLICANT COPY  
EXPENSE CLAIM DETAILS**

Recommended Coding							
<ul style="list-style-type: none"> <li>Local Travel – Staff - 62410000</li> <li>Staff Local Travel – Taxi – 62410001</li> <li>Staff Travel – UNA – 62410002</li> <li>Staff Provincial Travel – 62412000 (all expenses)</li> <li>Staff Out of Province Travel – 62414000 (all expenses)</li> </ul>				<ul style="list-style-type: none"> <li>Catering – 69600000</li> <li>Meals - 62410000</li> <li>Mileage – 62410000</li> <li>Course Registration &amp; Materials – 61030000</li> </ul>			
Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
Nov 21/07	Preventive Medicine 2008 Convention Registration Fee			\$495.00			
<b>Total km</b>							
<b>Rate as outlined in Section 2 – Travel below @</b>							
<b>Totals</b>							\$495.00

*US\$*

**EXPENSE LIMITS**

- Meal Allowances**  
When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:

  - Breakfast \$10.00 (if the departure time is earlier or the return time is later than 7:30 a.m.)
  - Lunch \$15.00 (if the departure time is earlier or the return time is later than 1:00 p.m.)
  - Dinner \$25.00 (if the departure time is earlier or the return time is later than 6:30 p.m.)

For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.  
Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.
- Travel**

  - Use of personal automobile – From March 1, 2006, reimbursement at the general rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
  - Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
  - Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
    - Monthly travel in excess of 340 kilometers; or
    - Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
    - Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
  - If union contract rate differs from \$0.43 then contract rate must be used.
  - Includes all forms of transportation costs, including taxis and buses for local travel.
  - Driving to and from work is not considered business travel and cannot be claimed.
- Advance**  
Travel advance may be requested provided travel expenses are likely to exceed \$500.

APPLICANT COPY

**Predy, Gerry Dr.**

---

**From:** meetings@acpm.org  
**Sent:** Wednesday, November 21, 2007 12:55 PM  
**To:** Predy, Gerry Dr.  
**Subject:** Preventive Medicine 2008

Your Registration Information  
=====

Invoice No.: 13717-100241  
Person Registered: Gerald Predy  
Company: Capital Health

Address:

Suite 300, 10216 - 124 Street  
Edmonton Alberta, T5N 4A3  
CD

Phone: 780-413-7600

Fax: 780-413-7950

Email: gerry.predy@capitalhealth.ca

Card Type: VISA

Card Holder: Gerald Predy

Card Number: \*\*\*

Card Expiration: s.17(1), 17(4)(e.1)

Billing Address:

Gerald Predy  
Suite 300, 10216 - 124 Street  
Edmonton AB, T5N 4A3  
CD

Package & Fees:

ACPM/APTR Member \$495.00

Total: \$495.00 *U*  
=====



## APPLICANT COPY

**MEETING HOME****REGISTRATION****SELECTED 2008  
ABSTRACTS****HOTEL/TRAVEL****EXHIBITS****SPONSORSHIP****SPEAKER PAGE****PROGRAM****PLANNING COMMITTEE****2007 PHOTO GALLERY****ABOUT ACPM****ACPM HOME**

## Registration

### Conference Registration Process

The American College of Preventive Medicine and the Association for Prevention Teaching and Research are committed to developing an easy and user friendly registration process for our conference attendees. For a stress free registration process, please review carefully the information outlined below.

**\*\*Registration fees includes continental breakfast, lunch and coffee breaks each day of the meeting as well as conference materials including a final program and a conference CD with all presentations\*\***

Attendees can register:

- **Online:** If paying by credit card please fill out the online registration form below. Make sure you enter your full name, institution and mailing address as confirmation letters will be mailed. ACPM will use your information when printing nametags as well. **Click here to register online!**
- **By mail or fax:** If paying by check, money order and credit card please download the **PDF version of the registration form**, fill it out, and mail or fax with payment to 1307 New York Avenue, N.W., Suite 200, Washington, DC 20005. Fax: 202.466.2662.

**Conference Speakers attending the full conference/One day only:** Conference speakers receive \$100 discount on the full registration rate if attending the full conference. If you are not attending the full conference only the day of your presentation please download the **PDF version of the registration form** and fax it to 202.466.2662. Make sure you mark the appropriate

## APPLICANT COPY

box.

**Note:** All speakers MUST register in advance to receive a conference nametag and materials onsite. Conference attendees must have a nametag to have access to conference activities.

**CME and MOC credits:** Please note that CME and MOC credits are free for ACPM members. The non-member rate is \$10 per credit. Please contact Jennifer Edwards at [jedwards@acpm.org](mailto:jedwards@acpm.org) for membership information.

**PLEASE NOTE:**

**ACPM doesn't accept registrations over the phone.**

### **Conference Fees**

Be sure to mark the appropriate registration rates as ACPM and APTR offer big discounts to its members. **Your membership must be current to receive the member rate. To join ACPM visit <http://www.acpm.org/mcat.htm>. To join APTR visit <http://www.aptrweb.org>.**

#### **Advance Conference Fees**

(Rates valid through December 1<sup>st</sup>, 2007)

#### **Advance Registration Fees for ACPM/APTR Members**

- ~~Advanced Member Fee- \$495~~
- Advance Resident/Student Member Fee-\$245
- Advance One Day only Member Fee-\$175

#### **Advance Registration Fees Non-Members**

- Advance Non-Member Fee-\$620
- Advance Resident/Student Non-Member Fee \$280
- Advance One Day only Non-Member Fee \$300

#### **Regular Conference Fees**

(Rates valid from December 2<sup>nd</sup>, 2007 to February 15<sup>th</sup>, 2008)

#### **Regular Registration Fees for ACPM/APTR Members**

## APPLICANT COPY

- Regular Member Fee- \$595
- Regular Resident/Student Member Fee-\$250
- Regular One Day only Member Fee-\$225

**Regular Registration Fees Non-Members**

- Regular Non-Member Fee- \$720
- Regular Resident/Student Member Fee-\$285
- Regular One Day only Non Member Fee-\$350

**Onsite Registration Fees**

(Rates valid February 16-23, 2008)

- Onsite Member Fee- \$645
- Onsite Non-Member Fee \$770
- Onsite One Day only Member Fee-\$275
- Onsite One Day only Non-Member Rate \$400

**Cancellation Policy:** All cancellations are subject to a \$100 administrative fee and must be in writing. Cancellation note must be received on or before **February 1<sup>st</sup>, 2008**. No refunds will be given after the deadline. No exceptions will be made.

**Click here to register online!**

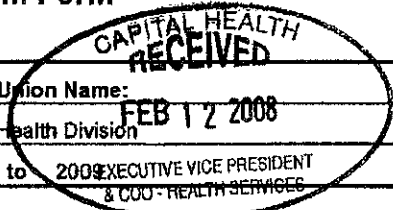
Questions? Please contact Haydee Barno, Director, Meetings & Events at [hbarno@acpm.org](mailto:hbarno@acpm.org) or call 202.466.2044 ext.103

For questions about membership please contact Jennifer Edwards, Director, Membership Services and Development at [jedwards@ACPM.org](mailto:jedwards@ACPM.org) or call 202.466.2044 ext. 104.

# APPLICANT COPY



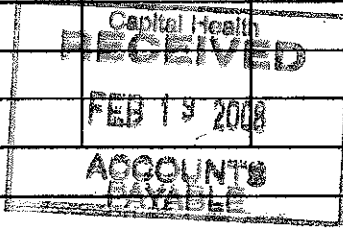
## Travel & Employee Expense Claim Form (In Canadian Dollars) s.17(1)



Name: Dr. Gerry Predy	Employee Number:	Union Name:
Position: Vice President Public Health/MOH	Department: Public Health Division	
Business Phone: 413-7600	Period From: 2008	to: 2009

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed/reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0007	71550300036	65090000			\$1,000.00	<input checked="" type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
Total							<input type="checkbox"/>



The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: Date: Feb 8/2008

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: MICHELE LAHEY <small>(Print name)</small>	Title: EXEC VP, COO HEALTH SERVICES	Phone #: 407-1671
(Signature)		Date: Feb. 14/08
Approved By:	Title:	Phone #
(Signature)		Date

- NOTE:**
- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
  - GST amounts included in the expense claims will be calculated by Accounts Payable.
  - Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
  - For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
  - For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
  - See page 2 of this form for expense claim limits.
  - Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
  - Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

**APPLICANT COPY  
EXPENSE CLAIM DETAILS**

**Recommended Coding**

- 61530030 – Workshop Fees & Materials
- 61520020 – Academic Course Fees & Materials
- 61540040 – Conference Fees & Materials
- 62300000 – Meals
- 62320000 – Staff Local Travel – Client Related
- 62310000 – Staff Local Travel – Non-Client Related
- 62320000 – Staff Local Travel – Taxi – Client Related
- 62310000 – Staff Local Travel – Taxi – Non-Client Related
- 62320000 – Staff Travel – UNA – Client Related
- 62310000 – Staff Travel – UNA – Non-Client Related
- 62312000 – Staff Provincial Travel – Non-Client Related
- 62314000 – Staff Out of Province Travel – Non-Client Related
- Catering – 69600000

Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
2008	Annual CMPA Fees					\$1,000.00	
<b>Total km</b>							
<b>Rate as outlined in Section 2 – Travel below @</b>							
<b>Totals</b>						1,000.00	

**EXPENSE LIMITS**

1. **Meal Allowances**  
 When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:
  - Breakfast \$10.00 (if the departure time is earlier or the return time is later than 7:30 a.m.)
  - Lunch \$15.00 (if the departure time is earlier or the return time is later than 1:00 p.m.)
  - Dinner \$25.00 (if the departure time is earlier or the return time is later than 6:30 p.m.)
 For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.  
 Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.
  
2. **Travel**
  - Use of personal automobile – From March 1, 2006, reimbursement at the general rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
  - Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
  - Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
    1. Monthly travel in excess of 340 kilometers; or
    2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
    3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
  - If union contract rate differs from \$0.43 then contract rate must be used.
  - Includes all forms of transportation costs, including taxis and buses for local travel.
  - Driving to and from work is not considered business travel and cannot be claimed.
  
3. **Advance**  
 Travel advance may be requested provided travel expenses are likely to exceed \$500.

**YOUR PAYMENT METHOD IS: Annual Direct Debit.**

Please do not send payment by cheque.



THE CANADIAN  
MEDICAL  
PROTECTIVE  
ASSOCIATION

L'ASSOCIATION  
CANADIENNE  
DE PROTECTION  
MEDICALE

# DIRECT DEBIT PLAN

DR GERALD PREDY  
300-10216 124 ST NW  
EDMONTON AB T5N 4A3

For Office Use Only:		s.17(1)		TOTAL FEE: \$ 1,284.00	
MEMBER NUMBER:		APM re-implementation fees		284.00	
0010478174		DD 1DD		1070.00	

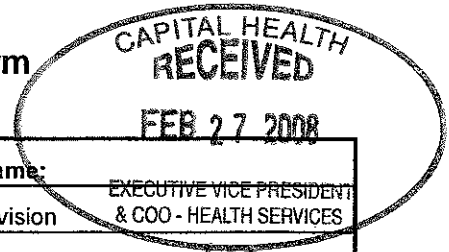


**Capital Health**  
EDMONTON AREA

APPLICANT COPY

**Travel & Employee Expense Claim Form**

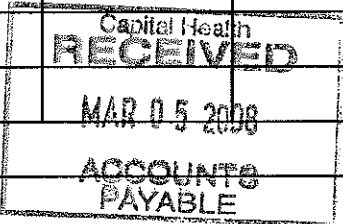
(In Canadian Dollars) s.17(1)



<b>Name:</b> Dr. Gerry Predy	<b>Employee Number:</b>	<b>Union Name:</b>
<b>Position:</b> VP Public Health/Medical Officer of Health	<b>Department:</b> Public Health Division	
<b>Business Phone:</b> 413-7600	<b>Period From:</b> February 19/08 to February 20/08	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0007	71550300036	62310000			165.00	<input checked="" type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
<b>Less Cash Advance</b>							<input type="checkbox"/>
<b>Total</b>						165.00	<input type="checkbox"/>



5%

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

**Employee Signature:** **Date:** Feb 27/08

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

<b>Approved By:</b> (Print name) <i>Michele Uehy</i>	<b>Title:</b>	<b>Phone #</b>
(Signature)		<b>Date</b> FEB 28 2008
<b>Approved By:</b> (Print name)	<b>Title:</b>	<b>Phone #</b>
(Signature)		<b>Date</b>

- NOTE:**
- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
  - GST amounts included in the expense claims will be calculated by Accounts Payable.
  - Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
  - For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
  - For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
  - See page 2 of this form for expense claim limits.
  - Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
  - Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

**APPLICANT COPY**  
**EXPENSE CLAIM DETAILS**

Recommended Coding							
<ul style="list-style-type: none"> <li>Local Travel – Staff - 62410000</li> <li>Staff Local Travel – Taxi – 62410001</li> <li>Staff Travel – UNA – 62410002</li> <li>Staff Provincial Travel – 62412000 (all expenses)</li> <li>Staff Out of Province Travel – 62414000 (all expenses)</li> </ul>				<ul style="list-style-type: none"> <li>Catering – 69600000</li> <li>Meals - 62410000</li> <li>Mileage – 62410000</li> <li>Course Registration &amp; Materials – 61030000</li> </ul>			
Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
Feb 19	Taxi Fare To/from Airport				110.00		
Feb 20	Taxi Fare To/From Airport	Canceled by @			55.00		
	(unable to fly out because of airport runway issues by friend)						
	of airport runway issues (P&IS)						
	weather (Feb 20)						
	So trip cancelled						
<b>Total km</b>							
<b>Rate as outlined in Section 2 – Travel below @</b>							
<b>Totals</b>					165.00		

**EXPENSE LIMITS**

- Meal Allowances**  
When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:
  - Breakfast \$10.00 (if the departure time is earlier or the return time is later than 7:30 a.m.)
  - Lunch \$15.00 (if the departure time is earlier or the return time is later than 1:00 p.m.)
  - Dinner \$25.00 (if the departure time is earlier or the return time is later than 6:30 p.m.)
 For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.  
Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.
- Travel**
  - Use of personal automobile – From March 1, 2006, reimbursement at the general rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
  - Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
  - Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
    - Monthly travel in excess of 340 kilometers; or
    - Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
    - Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
  - If union contract rate differs from \$0.43 then contract rate must be used.
  - Includes all forms of transportation costs, including taxis and buses for local travel.
  - Driving to and from work is not considered business travel and cannot be claimed.
- Advance**  
Travel advance may be requested provided travel expenses are likely to exceed \$500.



APPLICANT COPY

Date 19.02. Amount \$ 55.-  
Moutant GST Included

From/De \_\_\_\_\_  
To/A \_\_\_\_\_  
To/A \_\_\_\_\_  
Driver Peter Car # 107  
Chauffeur Voiture

**425-8310** www.co-optaxi.com **425-2525**

From \_\_\_\_\_  
To \_\_\_\_\_  
Time \_\_\_\_\_  
Date \_\_\_\_\_  
Trip Amount 55.00  
Driver Name Ali  
Car number \_\_\_\_\_  
GST 337

Date Feb 20 Amount 55.00  
Moutant GST Included

From/De \_\_\_\_\_  
To/A AIRPORT  
To/A \_\_\_\_\_  
Driver \_\_\_\_\_ Car # \_\_\_\_\_  
Chauffeur Voiture

**425-8310** www.co-optaxi.com **425-2525**

**Travel & Employee Expense Claim Form**

(In Canadian Dollars)

s.17(1)

**COPY**

<b>Name:</b> Dr. Gerry Predy	<b>Employee Number:</b>	<b>Union Name:</b>
<b>Position:</b> Vice President Public Health/MOH	<b>Department:</b> Public Health Division	
<b>Business Phone:</b> 413-7600	<b>Period From:</b>	<b>to</b>

**CAPITAL HEALTH RECEIVED**  
MAY 14 2008  
EXECUTIVE VICE PRESIDENT & COO - HEALTH SERVICES

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0007	71550300036	62314000			498.66	<input checked="" type="checkbox"/>
					① 23.80		<input type="checkbox"/>
					① 412.86		<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
<b>Less Cash Advance</b>							<input type="checkbox"/>
<b>Total</b>						498.66	<input type="checkbox"/>

Capital Health RECEIVED  
MAY 23 2008  
ACCOUNTS PAYABLE

Capital Health RECEIVED  
MAY 09 2008  
ACCOUNTS PAYABLE

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

**Employee Signature:** *[Signature]* **Date:** April 21/08

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

<b>Approved By:</b> (Print name) MICHELE LAHEY	<b>Title:</b> Executive VP & COO Health Services.	<b>Phone #</b>
(Signature)		<b>Date</b>
<b>Approved By:</b> (Print name) Michele Lahey	<b>Title:</b>	<b>Phone #</b>
(Signature)		<b>Date</b> May 13/08

- NOTE:**
- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
  - GST amounts included in the expense claims will be calculated by Accounts Payable.
  - Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
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  - For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
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  - Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
  - Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

# APPLICANT COPY EXPENSE CLAIM DECLARATION

Recommended Coding							
<ul style="list-style-type: none"> <li>• 61530030 – Workshop Fees &amp; Materials</li> <li>• 61520020 – Academic Course Fees &amp; Materials</li> <li>• 61540040 – Conference Fees &amp; Materials</li> <li>• 62300000 – Meals</li> <li>• 62320000 – Staff Local Travel – Client Related</li> <li>• 62310000 – Staff Local Travel – Non-Client Related</li> <li>• 62320000 – Staff Local Travel – Taxi – Client Related</li> </ul>				<ul style="list-style-type: none"> <li>• 62310000 – Staff Local Travel – Taxi – Non-Client Related</li> <li>• 62320000 – Staff Travel – UNA – Client Related</li> <li>• 62310000 – Staff Travel – UNA – Non-Client Related</li> <li>• 62312000 – Staff Provincial Travel – Non-Client Related</li> <li>• 62314000 – Staff Out of Province Travel – Non-Client Related</li> <li>• Catering – 69600000</li> </ul>			
Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
April 16	Victoria to <del>Edmonton</del>						36
	Airport drop Cab fare Victoria				60.00		
April 16/17	one dinner & one lunch		140.00				
April 18	Cab fare				66.00		
April 18	Hotel @ Edm				93.00		
April 19	Airport Hotel Sun Bay						36
	Hotel Accomodation	273.70					
<b>Total km</b>							7200
<b>Rate as outlined in Section 2 – Travel below @</b>							.43
<b>Totals</b>		273.70	40.00		159.00		3096

**EXPENSE LIMITS**

**1. Meal Allowances**

When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:

- Breakfast \$10.00 (if the departure time is earlier or the return time is later than 7:30 a.m.)
- Lunch \$15.00 (if the departure time is earlier or the return time is later than 1:00 p.m.)
- Dinner \$25.00 (if the departure time is earlier or the return time is later than 6:30 p.m.)

For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.

Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.

**2. Travel**

- Use of personal automobile – From March 1, 2006, reimbursement at the general rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
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- Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
  1. Monthly travel in excess of 340 kilometers; or
  2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
  3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
- If union contract rate differs from \$0.43 then contract rate must be used.
- Includes all forms of transportation costs, including taxis and buses for local travel.
- Driving to and from work is not considered business travel and cannot be claimed.

**3. Advance**

Travel advance may be requested provided travel expenses are likely to exceed \$500.

APPLICANT COPY



LAUREL  
POINT INN

Gerry Predy  
300 10216-124 Street  
Edmonton, AB T5N 4A3  
Canada

Room No. : 335  
Arrival : 04/16/08  
Departure : 04/18/08  
Folio No. :  
Conf. No. : 168901  
Cashier No. : 31

Date	Description	Charges	Credits
04/16/08	Room	119.00	
04/17/08	Room	119.00	
04/17/08	Provincial Hotel Tax 8%	19.04	
04/17/08	Municipal Hotel Tax 2% s.17(1), 17(4)(e.1)	4.76	
04/17/08	Goods and Service Tax 5%	11.90	
04/18/08	Visa XX/XX		273.70
<b>Total Charges</b>		<b>273.70</b>	
<b>Total Credits</b>			<b>273.70</b>
<b>Balance</b>			<b>0.00</b>
			<b>CAD</b>

<b>Net Amount</b>	<b>238.00</b>
<b>Provincial Hotel Tax 8%</b>	<del>19.04</del>
<b>Municipal Hotel Tax 2%</b>	<del>4.76</del>
<b>Goods and Service Tax 5%</b>	<b>11.90</b>
	<b>0.00</b>
	<b>0.00</b>
<b>Total Charges</b>	<b>0.00</b>
	<b>CAD</b>

APPLICANT COPY

THANK YOU FOR RIDING WITH  
 YELLOW CAB OF VICTORIA  
 DATE: 16-04-2008  
 TIME: 13:38  
 MDT ID: 17  
 BAUGE#: 6500

METER: 3055

PICKUP: 999  
 DROPOFF: 007

FARE: 60.05

TOTAL 60.05

THANK YOU FOR YOUR PATRONAGE  
 (250-381-2222)

**Bluebird Cabs Ltd.**

**1-800-665-7055**

**382-4235**  
 24 HOUR COURIER

SERVING  
 GREATER VICTORIA  
 SINCE 1946

**384-1155**  
 DELIVERY SERVICE

Date

*18/04/08*

Amount \$

*61.00*  
~~76~~

From

*Montreal*

To

*Airport*

Driver

*22*

Car #

*76*

Fare includes G.S.T. G.S.T. #

GST# R128599776

Edmonton Airports

Can - Edmonton  
 Tax CodeCA5%

Exit #1 Ca 18/04/08 16:32  
 Casier 8  
 Receipt 015925

Short-term parking tkt  
 VP - NO. 027413  
 16/04/08 11:04 -  
 18/04/08 16:32  
 Period 2d5h29'  
 (Tax) \$.

Total \$33.00

Payment Received  
 Check \$33.00

Sub Total \$31.43  
 Tax 5%

Deliv. Date=Receipt Date

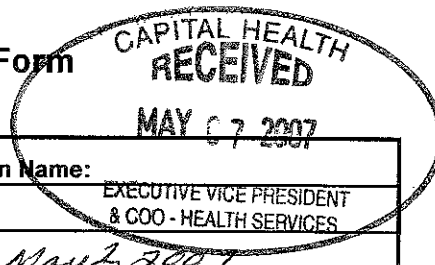


**Capital Health**  
EDMONTON AREA

APPLICANT COPY

**Travel & Employee Expense Claim Form**

(In Canadian Dollars) s.17(1)



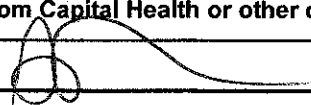
Name: <i>Dr. G. Predy</i>	Employee Number:	Union Name:
Position: <i>VP Public Health, KCH</i>	Department:	EXECUTIVE VICE PRESIDENT & COO - HEALTH SERVICES
Business Phone: <i>413-7600</i>	Period From: <i>Apr 30, 2007</i>	to <i>May 2, 2007</i>

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

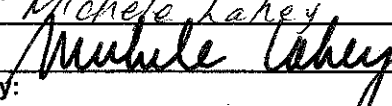
Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
<i>201</i>	<i>0007</i>	<i>71550300036</i>	<i>62414000</i>			<i>600.83</i>	<input type="checkbox"/>
		<i>69600 = 158.47w</i>					<input type="checkbox"/>
		<i>30.00w</i>	<b>ACCRUED</b>				<input type="checkbox"/>
		<i>62414 = 397.80w</i>	<i>MAY 14 2007</i>				<input type="checkbox"/>
		<i>14.56w</i>					<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
Total							<input type="checkbox"/>

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature:  Date: *May 3, 2007*

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: (Print name) <i>Michele Lakey</i>	Title: <i>Exec VP &amp; COO Health Services</i>	Phone # <i>1407-1671</i>
(Signature) 		Date <i>May 9/07</i>
Approved By: (Print name)	Title:	Phone #
(Signature)		Date

- NOTE:**
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  - Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

# APPLICANT GORY

## EXPENSE CLAIM DETAILS

Recommended Coding						
<ul style="list-style-type: none"> <li>• Local Travel – Staff - 62410000</li> <li>• Staff Local Travel – Taxi – 62410001</li> <li>• Staff Travel – UNA – 62410002</li> <li>• Staff Provincial Travel – 62412000 (all expenses)</li> <li>• Staff Out of Province Travel – 62414000 (all expenses)</li> </ul>			<ul style="list-style-type: none"> <li>• Catering – 69600000</li> <li>• Meals - 62410000</li> <li>• Mileage – 62410000</li> <li>• Course Registration &amp; Materials – 61030000</li> </ul>			
Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	(Hosts) Other Mileage km
April 28	Dinner with various board members (Hosted) Staff		<del>100.00</del> 0			188.47
April 30	Travel to Winnipeg to Urban public health network meeting	235.00	50.00 (Dinner x 2)	w	20.00 (taxi) w 25.50 (party) w	74 km <span style="float: right;">Air port</span>
<b>Total km</b>						<b>74</b>
<b>Rate as outlined in Section 2 – Travel below @</b>						<b>43</b>
<b>Totals</b>		<b>235.00</b>	<b>100.00</b>		<b>45.50</b>	<b>188.47</b>
						<b>31.82</b>

### EXPENSE LIMITS

#### 1. Meal Allowances

220.48 w  
19.56 n

When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:

- Breakfast \$10.00 (if the departure time is earlier or the return time is later than 7:30 a.m.)
- Lunch \$15.00 (if the departure time is earlier or the return time is later than 1:00 p.m.)
- Dinner \$25.00 (if the departure time is earlier or the return time is later than 6:30 p.m.)

For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.

Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.

#### 2. Travel

- Use of personal automobile – From March 1, 2006, reimbursement at the general rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
- Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
- Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
  1. Monthly travel in excess of 340 kilometers; or
  2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
  3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
- If union contract rate differs from \$0.43 then contract rate must be used.
- Includes all forms of transportation costs, including taxis and buses for local travel.
- Driving to and from work is not considered business travel and cannot be claimed.

#### 3. Advance

Travel advance may be requested provided travel expenses are likely to exceed \$500.



APPLICANT COPY

ROOM / CHAMBRE 1417  
 CASHIER / CAISSIER(E) 28  
 PAGE 1  
 CUSTOMER(S) / CLIENT(S) 1

350 St. Mary Ave., Winnipeg, Manitoba R3C 3J2  
 Tel.: (204) 942-0551 • Fax: (204) 943-4627

ARRIVAL / ARRIVÉE 04/30/07  
 DEPARTURE / DÉPART 05/02/07

Dr Gerry Predy  
 Suite 300  
 10216 124th St  
 Edmonton, AB T5N 4A3  
 CANADA

DATE	DESCRIPTION	CHARGES FRAIS	CREDITS CREDITS
04/30	Room Charge	104.00	
04/30	GST Room	6.24	
04/30	PST Room	7.28	
05/01	Room Charge	104.00	
05/01	GST Room	6.24	
05/01	PST Room	7.28	
05/02	VISA XX/XX		235.04
		235.04	235.04
	s.17(1), 17(4)(e.1)		0.00 CAD
GST Room	(6.0%) 12.48		
GST F & B	(6.0%) 0.00		
GST Other	(6.0%) 0.00		
Total GST	(6.0%) 12.48		
GST Vendor	139445290 RT0020		

I agree that my liability for this bill is not waived and agree to be held personally liable in the event that the indicated person, company or association fails to pay for any part of the full amount of these charges. Delta Hotels agrees to transmit to credit card issuer for payment. Merchandise/or services purchased on this credit card shall not be resold for a cash refund.

Je m'engage personnellement à acquitter les frais encourus soit en partie, soit en entier, à défaut de paiement complet par la compagnie, l'association ou son représentant désigné. Delta Hôtels convient de transmettre cette note au fournisseur de la carte de crédit pour paiement. Les achats en biens et services effectués avec cette carte de crédit ne peuvent être revendus pour un remboursement en espèces.

X \_\_\_\_\_  
 Guest's Signature / Signature du client



APPLICANT COPY

EDMONTON AIRPORT  
GST# R128599776

Car park 0000001009 Phone: (780)990-8439  
Fax: (780)990-8329

Receipt no. 0110/0750/00801 02.05.07

015100 pay parking ticket 25.50 \$  
30.04.07 11:35 - 02.05.07 16:51  
Length of stay: 2 Dy. 5 Hr. 16 Min.

total amount 25.50 \$

accepted total 25.50 \$  
G.S.T. 0.00 % 1.44 \$

Thank you for your patronage!  
Please Come Again!  
\*\* Open 24 hours \*\*  
\*\* Thank you \*\*

HARDWARE GRILL  
9698 JASPER AVENUE  
EDMONTON AB  
S.17(1), 17(4)(e.1)

CARD NUMBER  
CARD TYPE VISA 0920  
DATE/TIME 2007/04/16 19:37:22  
RECEIPT NUMBER 508538997-001-044-002  
PRE-AUTHORIZATION  
AMOUNT \$158.47

TIP  
TOTAL AMOUNT 188.47

01 APPROVED - 027 AUTH. # 016814  
THANK YOU

CARDHOLDER COPY

DRIVER  
CAR AMOUNT 20.00  
TO Air Port  
TRIP FROM Self  
DATE May 2/07

Thanks again!  
...and do call us  
UNICITY TAXI LTD  
(204) 925-3131

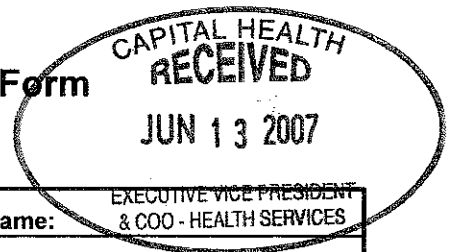


APPLICANT COPY

Travel & Employee Expense Claim Form

(In Canadian Dollars)

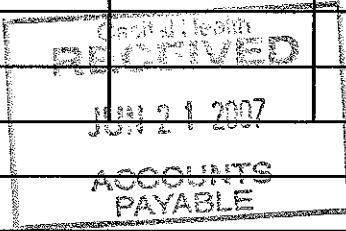
s.17(1)



Name: <i>G. PREDY</i>	Employee Number:	Union Name: EXECUTIVE VICE PRESIDENT & COO - HEALTH SERVICES
Position: <i>VP PM</i>	Department:	
Business Phone:	Period From: to	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
<i>201</i>	<i>0007</i>	<i>71550300036</i>	<i>62414000</i>			<i>378.90</i>	<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance					<i>358.20 w</i>		<input type="checkbox"/>
Total					<i>20.70 n</i>	<i>378.90</i>	<input type="checkbox"/>



The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: *[Signature]* Date: *June 13 2007*

Approved By: (Print name)	Title:	Phone #
(Signature) <i>Michele Cahery</i>		Date <i>JUN 14 2007</i>
Approved By: (Print name)	Title:	Phone #
(Signature)		Date

- NOTE:
- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
  - GST amounts included in the expense claims will be calculated by Accounts Payable.
  - For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
  - For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
  - See the other side of this form for expense claim limits.
  - Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
  - Out of province expenses also require approval of Chief Operating Officer or Vice President.





APPLICANT COPY  
HOTEL  
GRAND PACIFIC

463 Belleville Street, Victoria, BC, Canada V8V 1X3 Tel: (250) 386-0450 Guest Fax: (250) 380-4473

Reservations 1-800-663-7550  
Member of Preferred Hotels & Resorts Worldwide

Gerry Predy

CA

Room : 0203  
Arrival Date : 05-31-07  
Departure Date : 06-01-07  
Folio No. : 5205  
Conf. No. : 410167  
Cashier No. : 9

**INVOICE**

Invoice No. :  
A/R Number :  
Group Code :  
Company Name :

06-01-07

Date	Description	Debit	Credit
05-31-07	Room Charge	207.00	
05-31-07	Room GST s.17(1), 17(4)(e.1)	12.42	
05-31-07	Room TAX	20.70	
06-01-07	Visa <span style="float: right;">XX/XX</span>		240.12
Room GST Total - 12.42		<b>Total</b>	<b>240.12</b>
Other GST Total - 0.00			<b>240.12</b>
GST # 122212624		<b>Balance</b>	<b>0.00</b>

I agree that my liability for this bill is not waived and agree to be held personally liable in the event that the indicated person, company or association fails to pay for any part or the full amount of these charges. I have accepted delivery of the Globe and Mail. If refused, a \$.50 (Mon to Fri) and a \$1.25 (Sat) credit will be applied to my account.



APPLICANT COPY

**Express TAXI**

**(250) 381-2222**

Box 487, COMMITTED TO YOUR SERVICE 24 HOURS A DAY  
Victoria, BC Canada V8W 2N8

Toll Free 1-800-808-6881 anywhere in North America

DATE 31/05/07

RECEIVED FROM \_\_\_\_\_

\$ 65.00

FROM Airport TO 1900 Richmond Ave

CAB NO. 35 DRIVER \_\_\_\_\_



GST INCLUDED

**382-4235**  
24 HOUR COURIER

SERVING  
GREATER VICTORIA  
SINCE 1946

**384-1155**  
DELIVERY SERVICE

**1-800-665-7055**

*Bluebird Cabs Ltd.*

Date 31 May 2007 Amount \$ 12.00  
From 463 Bellwood Pl  
To 1736  
Driver J. G. G. Car # 67  
Fare includes G.S.T. G.S.T. # \_\_\_\_\_

**EDMONTON AIRPORTS**

ICF# R12358776

Car park 0000903089 phone: (780) 391-8439  
Fax: (780) 391-8329

Receipt no. 0183/0755/0060 01.06.07

015100 pay parking ticket 19.10 \$  
31.05.07 09:36 01.06.07 18:27  
Length of stay: 1 Day, 3 Hrs, 51 Min.

**Total amount 19.10 \$**

Account total 19.10 \$  
G.S.T. 6.00 % 1.09 \$

Thank you for your patronage!  
Please Come Again!  
\*\* Open 24 hours \*\*  
\*\* Thank you \*\*

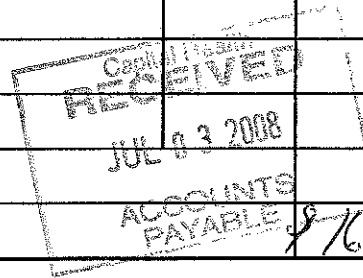
**Travel & Employee Expense Claim Form**

(In Canadian Dollars) s.17(1)

<b>Name:</b> Dr. Gerry Predy	<b>Employee Number:</b>	<b>Union Name:</b>
<b>Position:</b> VP Public Health/Medical Officer of Health	<b>Department:</b> Public Health Division	
<b>Business Phone:</b> 413-7600	<b>Period From:</b> June 9/08 to June 9/08	

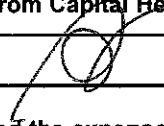
Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included	
201	0007	71550300036	62312000			165.00	<input type="checkbox"/>	
							<input type="checkbox"/>	
							<input type="checkbox"/>	
							<input type="checkbox"/>	
							<input type="checkbox"/>	
							<input type="checkbox"/>	
							<input type="checkbox"/>	
<b>Less Cash Advance</b>							<input type="checkbox"/>	
<b>Total</b>							165.00	<input type="checkbox"/>

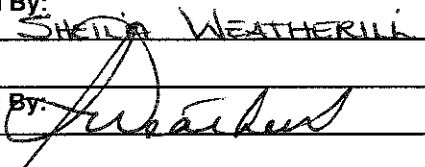
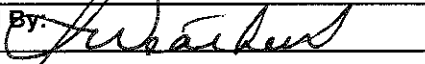


The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

**Employee Signature:**  **Date:** June 16/08

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

<b>Approved By:</b> (Print name) SHEILA WEATHERILL	<b>Title:</b> PRESIDENT & CEO.	<b>Phone #</b>
(Signature) 		<b>Date</b>
<b>Approved By:</b> (Print name) 	<b>Title:</b>	<b>Phone #</b>
(Signature)		<b>Date</b>

- NOTE:**
- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
  - GST amounts included in the expense claims will be calculated by Accounts Payable.
  - Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
  - For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
  - For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
  - See page 2 of this form for expense claim limits.
  - Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
  - Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

## APPLICANT COPY

### EXPENSE CLAIM DETAILS

Recommended Coding							
<ul style="list-style-type: none"> <li>• Local Travel – Staff - 62410000</li> <li>• Staff Local Travel – Taxi – 62410001</li> <li>• Staff Travel – UNA – 62410002</li> <li>• Staff Provincial Travel – 62412000 (all expenses)</li> <li>• Staff Out of Province Travel – 62414000 (all expenses)</li> </ul>				<ul style="list-style-type: none"> <li>• Catering – 69600000</li> <li>• Meals - 62410000</li> <li>• Mileage – 62410000</li> <li>• Course Registration &amp; Materials – 61030000</li> </ul>			
Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
Apr 9/07	Ment. Nobilcon Company Med Dev						330
						<b>Total km</b>	330
						<b>Rate as outlined in Section 2 – Travel below @</b>	
<b>Totals</b>							#165.00

#### EXPENSE LIMITS

1. **Meal Allowances**  
 When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:
  - Breakfast \$10.00 (if the departure time is earlier or the return time is later than 7:30 a.m.)
  - Lunch \$15.00 (if the departure time is earlier or the return time is later than 1:00 p.m.)
  - Dinner \$25.00 (if the departure time is earlier or the return time is later than 6:30 p.m.)
 For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.  
 Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.
2. **Travel**
  - Use of personal automobile – From March 1, 2006, reimbursement at the general rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
  - Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
  - Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
    1. Monthly travel in excess of 340 kilometers; or
    2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
    3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
  - If union contract rate differs from \$0.43 then contract rate must be used.
  - Includes all forms of transportation costs, including taxis and buses for local travel.
  - Driving to and from work is not considered business travel and cannot be claimed.
3. **Advance**  
 Travel advance may be requested provided travel expenses are likely to exceed \$500.

**Travel & Employee Expense Claim Form**

(In Canadian Dollars) s.17(1)

<b>Name:</b> Dr. Gerry Predy	<b>Employee Number:</b>	<b>Union Name:</b>
<b>Position:</b> VP Public Health/Medical Officer of Health		<b>Department:</b> Public Health Division
<b>Business Phone:</b> 413-7600	<b>Period From:</b> June 18/08 to June 20/08	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form


Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST Included
201	0007	71550300036	61540040			611.32	<input type="checkbox"/>
							<input type="checkbox"/>
		ACCRUED					<input type="checkbox"/>
		JUL 0 2 2008					<input type="checkbox"/>
						32	<input type="checkbox"/>
<b>Less Cash Advance</b>						612.38	<input type="checkbox"/>
<b>Total</b>						611.32	<input type="checkbox"/>

366.67  
245.69

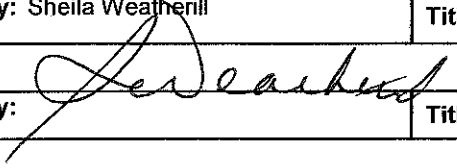
Capital Health RECEIVED  
JUL 0 3 2008  
ACCOUNTS PAYABLE

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

**Employee Signature:**  **Date:** Jun 24/08

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

<b>Approved By:</b> Sheila Weatherill (Print name)	<b>Title:</b> President & CEO	<b>Phone #</b>
(Signature) 		<b>Date</b>
<b>Approved By:</b>	<b>Title:</b>	<b>Phone #</b>
(Signature)		<b>Date</b>

- NOTE:**
- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
  - GST amounts included in the expense claims will be calculated by Accounts Payable.
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  - For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
  - See page 2 of this form for expense claim limits.
  - Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
  - Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP



# APPLICANT COPY

## EXPENSE CLAIM DETAIL

Recommended Coding							
<ul style="list-style-type: none"> <li>• Local Travel – Staff - 62410000</li> <li>• Staff Local Travel – Taxi – 62410001</li> <li>• Staff Travel – UNA – 62410002</li> <li>• Staff Provincial Travel – 62412000 (all expenses)</li> <li>• Staff Out of Province Travel – 62414000 (all expenses)</li> </ul>				<ul style="list-style-type: none"> <li>• Catering – 69600000</li> <li>• Meals - 62410000</li> <li>• Mileage – 62410000</li> <li>• Course Registration &amp; Materials – 61030000</li> </ul>			
Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
	Albert Werber not near						
June 18	Trunkway		D-25.00				42km
June 19			D-25.00				
June 20	Hotel	280.00	42.00 w				
	Car Rental		238.00 n	171.02	178.77		
	+Gasoline			7.69	38.55 w		
	Parking @ airport					29.80 w	
	Travel for airport						40km
<b>Total km</b>							82
<b>Rate as outlined in Section 2 – Travel below @</b>							.43
<b>Totals</b>		280.00	50.00		216.26	29.80	35.26
							217.32

**EXPENSE LIMITS**

1. **Meal Allowances**  
 When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:
  - Breakfast \$10.00 (if the departure time is earlier or the return time is later than 7:30 a.m.)
  - Lunch \$15.00 (if the departure time is earlier or the return time is later than 1:00 p.m.)
  - Dinner \$25.00 (if the departure time is earlier or the return time is later than 6:30 p.m.)
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  - Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
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    2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
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  - If union contract rate differs from \$0.43 then contract rate must be used.
  - Includes all forms of transportation costs, including taxis and buses for local travel.
  - Driving to and from work is not considered business travel and cannot be claimed.
  
3. **Advance**  
 Travel advance may be requested provided travel expenses are likely to exceed \$500.

# APPLICANT COPY

Contract 1171171

REFFRY DREDDY

s.17(1)

----- Rental Summary -----

		Date	Time	Odom	Gas	Loc.
1. Unit #: 0422483						
Rented Class: ICAR	Lic: 536DNR	06/18/08	14.48	13262	8	YVR
2008 DODGE AVENGER	VIN: 1B3LC56R88N166726	In: 06/20/08	13.51	13541	8	YVR

----- Charge Summary -----

Description		Rate	Charge	Free Mls
Regular: Daily	2 @	41.06	82.12	0
Net T&M Charges			82.12	
PDW-CD:	2 @	24.99 /day	49.98	
Misc Fee: PLC		17.750%	24.10	
Misc Chg: Road Tax	2 @	1.50 /day	3.00	
Misc Chg: VLATR	2 @	1.84 /day	3.68	
Tax: GST		5.000%	8.14	
Tax: PST		7.000%	7.69	
Total Charges			178.71	
Payment VI		06/20	264.44	
Payment VI		06/20	-85.73	
Total Payments	s.17(1), 17(4)(e.1)		178.71	
Balance Due			0.00	

APPLICANT COPY



DELTA

WHISTLER VILLAGE SUITES

ROOM / CHAMBRE 1525  
 CASHIER / CASSIER(E) 16  
 PAGE 1  
 CUSTOMER(S) / CLIENT(S) 1

4308 Main Street, Whistler, British Columbia V0N 1B4  
 Tel.: (604) 905-3987 • Fax: (604) 938-6500

ARRIVAL / ARRIVÉE 06/18/08 17:25  
 DEPARTURE / DÉPART 06/20/08 07:55

Dr Gerry Predy  
 Suite 300  
 10216 124th St  
 Edmonton, AB T5N 4A3  
 Dr Gerry Predy

I N V O I C E N O. 239860 Delta Whistler Village Suites, 06/20/08

DATE	DESCRIPTION	CHARGES FRAIS	CREDITS CREDITS
06/18	Room Charge	119.00	
06/18	Parking	20.00	
06/18	GST Parking	1.00	
06/18	ADVANCE DEPOSIT		273.70
06/19	Room Charge	119.00	
06/19	Parking	20.00	
06/19	GST Parking	1.00	
06/20	VISA XX/XX		6.30
s.17(1), 17(4)(e.1) Total		280.00	280.00
Balance			0.00 CAD
GST Room	(5.0%) 0.00		
GST F & B	(5.0%) 0.00		
GST Other	(5.0%) 2.00		
Total GST	(5.0%) 2.00		
GST Vendor	873265771	The ADVANCE DEPOSIT line on your invoice includes all amounts processed prior to arrival.	
WE WOULD LOVE TO WELCOME YOU BACK - Call 1.888.299.3987 and quote "SSB" to receive our Exclusive Return Guest Rate.			

I agree that my liability for this bill is not waived and agree to be held personally liable in the event that the indicated person, company or association fails to pay for any part or the full amount of these charges. Delta agrees to transmit to credit card issuer for payment. Merchandise/or services purchased on this credit card shall not be resold for a cash refund. I have accepted delivery of The Globe and Mail. Had I refused, I would have been eligible for a \$0.75 (Mon.-Fri.) and \$1.50 (Sat.) credit to my account. (At participating hotels.)

Je m'engage personnellement à acquitter les frais encourus soit en partie, soit en entier, à défaut de paiement complet par la compagnie, l'association ou son représentant désigné. Delta Hôtels convient de transmettre cette note au fournisseur de la carte de crédit pour paiement. Les achats en biens et services effectués avec cette carte de crédit ne peuvent être revendus pour un remboursement en espèces. J'ai accepté la livraison du Globe and Mail. Si j'avais refusé, j'aurais pu obtenir un crédit à mon compte de 0,75 \$ (lundi au vendredi) et de 1,50 \$ le samedi (Dans les hôtels participants.)

X \_\_\_\_\_  
 Guest's Signature / Signature du client

APPLICANT COPY

PETRO-CANADA  
5111 GRT MCCHONACI  
RICHMOND  
BC V7B 1K3

RST: 860104120 (604) 231 4140  
2008-06-20 PC0348387:6812602 13.40  
TERMINAL: 016812602 OPER: A

6ST# R128599776

Edmonton Airports

Can-Edmonton  
Tax CodeCAS%

Exit #1 Ca 20/06/08 19:33  
Cashier 31  
Receipt 074592

Short-term parking tkt  
VP - No. 123436  
18/06/08 11:38 -  
20/06/08 19:33 -  
Period 2d7h56'  
(Tax) \$29.80

Total \$29.80

Payment Received

T4\$10.8  
Cash \$29.80

Sub Total \$10.8  
Tax 5% 1.42

Amount Paid \$40.00  
Change \$10.20

Deliv. Date=Receipt Date

Pump 1 (L) (\$/L) (\$)  
Regular 26.014 1.482 38.55\*  
Total Owed 38.55

TOTAL PAID 38.55  
CREDIT CARD

Taxes on 26.014 Litres of Regularren Fuel  
FET: \$0.1000/L = \$2.60  
PFT: \$0.2050/L = \$5.33  
GST: 5.00% = \$1.84  
Total Taxes: = \$9.77

\*TAXES INCL. #TAXES EXCL.

VISA INVOICE 633233 AUTH 056589  
s.17(1), 17(4)(e.1)

A chance to win  
FREE Gas  
for one year!

Did you see  
a Service Hero today?  
\*\*\*  
Full details and a short survey  
to be completed at

www.petro-  
canada.ca/hero  
or  
1-866-826-7



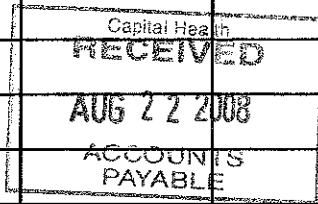
**Travel & Employee Expense Claim Form**

(In Canadian Dollars) s.17(1)

Name: <u>G. MORA</u>	Employee Number:	Union Name:
Position: <u>VP. Public Health Invt</u>	Department: <u>PUBLIC HEALTH.</u>	
Business Phone: <u>4137600</u>	Period From: <u>Aug 5</u>	to <u>Aug 19</u>

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	6007	71550300036	61540040			794.75	<input type="checkbox"/>
		62314 = 506.00					<input type="checkbox"/>
		61540040 = 288.75					<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
Total						794.75	<input type="checkbox"/>



The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: [Signature] Date: Aug 19/08

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: (Print name) <u>Allaudin Morali</u>	Title: <u>Executive Vice President &amp; Chief Financial Officer</u>	Phone #
(Signature) <u>[Signature]</u>		Date <u>Aug 21/08</u>
Approved By: (Print name)	Title:	Phone #
(Signature)		Date

- NOTE:**
- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
  - GST amounts included in the expense claims will be calculated by Accounts Payable.
  - Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
  - For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
  - For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
  - See page 2 of this form for expense claim limits.
  - Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
  - Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

**APPLICANT COPY**  
**EXPENSE CLAIM DETAILS**

**Recommended Coding**

- 61530030 – Workshop Fees & Materials
- 61520020 – Academic Course Fees & Materials
- 61540040 – Conference Fees & Materials
- 62300000 – Meals
- 62320000 – Staff Local Travel – Client Related
- 62310000 – Staff Local Travel – Non-Client Related
- 62320000 – Staff Local Travel – Taxi – Client Related
- 62310000 – Staff Local Travel – Taxi – Non-Client Related
- 62320000 – Staff Travel – UNA – Client Related
- 62310000 – Staff Travel – UNA – Non-Client Related
- 62312000 – Staff Provincial Travel – Non-Client Related
- 62314000 – Staff Out of Province Travel – Non-Client Related
- Catering – 69600000

Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
Aug 5/08	Attend WCC Kalamazoo		✓	288.75	W		
	Travel to Kalamazoo						1012.00
<b>Total km</b>							1012.00
<b>Rate as outlined in Section 2 – Travel below @</b>							.50
<b>Totals</b>				288.75			506.00

**EXPENSE LIMITS**

**1. Meal Allowances**

When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:

- Breakfast \$10.00 (if the departure time is earlier or the return time is later than 7:30 a.m.)
- Lunch \$15.00 (if the departure time is earlier or the return time is later than 1:00 p.m.)
- Dinner \$25.00 (if the departure time is earlier or the return time is later than 6:30 p.m.)

For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.

Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.

**2. Travel**

- Use of personal automobile – From March 1, 2006, reimbursement at the general rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
- Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
- Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
  1. Monthly travel in excess of 340 kilometers; or
  2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
  3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
- If union contract rate differs from \$0.43 then contract rate must be used.
- Includes all forms of transportation costs, including taxis and buses for local travel.
- Driving to and from work is not considered business travel and cannot be claimed.

**3. Advance**

Travel advance may be requested provided travel expenses are likely to exceed \$500.

APPLICANT COPY

**Predy, Gerry Dr.**

---

**From:** Registration Desk [registration@agendamanagers.com]  
**Sent:** Wednesday, June 11, 2008 3:53 AM  
**To:** Predy, Gerry Dr.  
**Subject:** - Registration Order # 18977

CONFERENCE/ CONFÉRENCE: 2008 National Collaborating Centres Summer Institute -

---

ORDER FOR/ DEMANDE POUR:

Gerry Predy  
VP Public Health & Medical Officer of Health Capital Health Suite 300 - 10216-124 Street  
Edmonton Alberta T5N 4A3  
(780) 413-7600  
(780) 413-7950  
gerry.predy@capitalhealth.ca  
Registration Date/ Date de l'inscription: 6/10/2008 5:56:18 PM

ORDER DETAILS/ DÉTAILS DE LA DEMANDE:

---

DIETARY RESTRICTIONS: unspecified

Do you wish to have your name in the directory distributed only for the Institute?: Yes

---

REGISTRATION DETAILS/ DÉTAILS DE L'INSCRIPTION:

---

1 Delegate Registration Fee @ \$275.00  
1 NCCHPP - Deliberative dialogue: A different way to gather evidence @ \$0.00  
1 NCCHPP - Interactive Workshop: Influencing Public Policy @ \$0.00  
1 NCCID - The Weakest Link: Organizational Development for the Implementation of Evidence @ \$0.00  
SUBTOTAL: \$275.00  
TAX: \$13.75  
TOTAL: \$288.75  
PAYMENT METHOD: Visa  
Auth. Code: 048839

Thank you very much for registering with Agenda Managers for the 2008 National Collaborating Centres Summer Institute. This mail has been sent by an automated attendant. Any inquiries about this order should be directed to registration@agendamanagers.com (email) or (902) 422-1886 (phone).

Merci de votre inscription auprès de Agenda Managers pour le 2008 National Collaborating Centres Summer Institute. Ce courriel vous a été envoyé par préposé automatique. Toute demande de renseignement peut être adressée à l'adresse registration@agendamanagers.com ou en téléphonant au (902) 422-1886.

.....

**Travel & Employee Expense Claim Form**

(In Canadian Dollars) s.17(1)

CAPITAL HEALTH  
SEP 10 2008  
REGISTRAR VICE PRESIDENT  
A. J. ...

Name: <i>G. Pardy</i>	Employee Number:	Union Name:
Position:	Department:	
Business Phone: <i>413-7600</i>	Period From: <i>Sept 8/08</i>	to

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
<i>201</i>	<i>0007</i>	<i>71550300034</i>	<i>62310000</i>			<i>42.82</i>	<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
Total						<i>42.82</i>	<input type="checkbox"/>

Capital Health  
**RECEIVED**  
SEP 12 2008  
ACCOUNTS  
PAYABLE

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: *[Signature]* Date: *Sept 9/08*

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: <i>COLLEEN PURDY</i> (Print name)	Title: <i>ACTING CFO</i>	Phone #
(Signature) <i>[Signature]</i>		Date <i>SEP 12 2008</i>
Approved By:	Title:	Phone #
(Signature)		Date

- NOTE:**
- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
  - GST amounts included in the expense claims will be calculated by Accounts Payable.
  - Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
  - For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
  - For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
  - See page 2 of this form for expense claim limits.
  - Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
  - Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP



**APPLICANT COPY**  
**EXPENSE CLAIM DECAL**

**Recommended Coding**

- 61530030 – Workshop Fees & Materials
- 61520020 – Academic Course Fees & Materials
- 61540040 – Conference Fees & Materials
- 62300000 – Meals
- 62320000 – Staff Local Travel – Client Related
- 62310000 – Staff Local Travel – Non-Client Related
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- 62320000 – Staff Travel – UNA – Client Related
- 62310000 – Staff Travel – UNA – Non-Client Related
- 62312000 – Staff Provincial Travel – Non-Client Related
- 62314000 – Staff Out of Province Travel – Non-Client Related
- Catering – 69600000

Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other <i>Per Diem</i>	Mileage km	
Sept 5/07	AMS Annual Adm. Team meet					11.00	74 km	
<b>Total km</b>							74 km	
<b>Rate as outlined in Section 2 – Travel below @</b>							.43	
<b>Totals</b>							11.00	31.82

**EXPENSE LIMITS**

**1. Meal Allowances**

When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:

- Breakfast \$10.00 (if the departure time is earlier or the return time is later than 7:30 a.m.)
- Lunch \$15.00 (if the departure time is earlier or the return time is later than 1:00 p.m.)
- Dinner \$25.00 (if the departure time is earlier or the return time is later than 6:30 p.m.)

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Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.

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- Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
- Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
  - 1. Monthly travel in excess of 340 kilometers; or
  - 2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
  - 3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
- If union contract rate differs from \$0.43 then contract rate must be used.
- Includes all forms of transportation costs, including taxis and buses for local travel.
- Driving to and from work is not considered business travel and cannot be claimed.

**3. Advance**

Travel advance may be requested provided travel expenses are likely to exceed \$500.

APPLICANT COPY

GST# R128599776

Edmonton Airports

Can- Edmonton  
Tax CodeCA5%

Exit #1 Ca 05/09/08 17:14  
Cashier 33  
Receipt 002008

Short-term parking tkt  
VP - No. 023415  
05/09/08 06:29 -  
05/09/08 17:14 -  
Period 0d10h46'  
(Tax) \$11.00

Total \$11.00

Payment Received  
Cash \$11.00

Sub Total \$10.48  
Tax 5% 0.52

Amount Paid \$20.00  
Change \$9.00

Deliv. Date=Receipt Date

APPLICANT COPY

**McGarvey, Gillian**

---

**From:** Sebulsky, Lavera  
**Sent:** Tuesday, September 02, 2008 7:16 PM  
**To:** McGarvey, Gillian  
**Subject:** FW: Travel Itinerary for Dr. Predy for Calgary

Hi Jill

Dr. Predy decided to fly to Calgary on Friday. Here is his itinerary.

Joanna P approved.

-----Original Message-----

**From:** Casandra Wagner [mailto:casandra.wagner@marlintravel.ca]  
**Sent:** Tuesday, September 02, 2008 4:20 PM  
**To:** Sebulsky, Lavera  
**Subject:** Travel Itinerary for Dr. Predy for Calgary

MARLIN TRAVEL - GOVERNMENT CENTRE  
OWNED AND OPERATED BY 101017690 SASK. LTD.  
9929 108TH ST - MAIN  
EDMONTON ALBERTA T5K 1G8  
PHONE: (780) 425-8611 FAX: (780) 426-5759  
BRANCH: N61107 GST REG NO. 885101915  
PNR LOC: KMJMPQ DATE: 02 SEP 2008  
AGENT: CASANDR

**TO:** CAPITAL HEALTH  
10030 - 107 STREET  
EDMONTON AB  
T5J 3E4  
**FOR:** PREDY/GERRY DR\*0007715503000036

--ITINERARY--

FROM	TO	CARRIER	FLT/CL	DATE	DEP	ARR	ST
EDMONTON/INTL	CALGARY	WESTJET	254 Y	05 SEP 08	740A	824A	OK
NONSTOP							
EQUIPMENT:736		TRAVELLING TIME - :44					
WESTJET CONFIRMATION DWCJDF							
CALGARY	EDMONTON/INTL	WESTJET	255 Y	05 SEP 08	420P	506P	OK
NONSTOP							
EQUIPMENT:736		TRAVELLING TIME - :46					
WESTJET CONFIRMATION DWCJDF							

04 MAR 09 TOUR  
WEDNESDAY LOCATION-EDMONTON/INTL

AIR FLIGHT ACCIDENT INSURANCE IS PROVIDED AT NO COST T  
FOR THE PRINCIPAL SUM \$100000 UNDER MASTER POLICY FL47  
UNDERWRITTEN BY AXA INSURANCE CANADA

24 HOUR EMERGENCY HELP DESK  
WITHIN CANADA OR UNITED STATES CALL ...1 800 267 8891  
OUTSIDE OF TOLL FREE AREA CALL COLLECT...715 346 0834

\*\*\*\*\*IMPORTANT REMINDER\*\*\*\*\*

**\*\*THE SPELLING OF THE PASSENGER S FULL NAMES\*\***  
**\*\*MUST BE IDENTICAL AS THE ONES SHOWN ON THEIR TRAVEL DOCUMENTS\*\***  
**\*\*PLEASE CONFIRM THE LUGGAGE ALLOWANCE FOR THIS\*\***  
**\*\*FILE DIRECTLY WITH THE CARRIERS INVOLVED\*\***

\*\*\*\*\*

-----WESTJET AIRLINE RULES-----

TICKET IS NON REFUNDABLE  
RESERVATION MAY BE CHANGED OR CANCELLED UP TO  
2 HOURS PRIOR TO DEPARTURE. CANCELLATION FEE 50.00.  
A CHANGE FEE OF 50.00 PLUS ANY FARE DIFFERENCE  
WILL BE CHARGED IN EACH DIRECTION.  
24 HOURS IN ADVANCE GO TO WWW.WESTJET.COM  
TO PRE-SELECT YOUR SEATS AND PRINTABLE BOARDING PASS

MARLIN TRAVEL - GOVERNMENT CENTRE  
OWNED AND OPERATED BY 101017690 SASK. LTD.  
9929 108TH ST - MAIN  
EDMONTON ALBERTA T5K 1G8  
PHONE: (780) 425-8611 FAX: (780) 426-5759  
BRANCH: N61107 GST REG NO. 885101915  
PNR LOC: KMJMPQ DATE: 02 SEP 2008  
AGENT: CASANDR

TO: CAPITAL HEALTH 10030 - 107 STREET EDMONTON AB T5J 3E4  
FOR: PREDY/GERRY DR\*0007715503000036

--ITINERARY--

FROM TO CARRIER FLT/CL DATE DEP ARR ST  
-----

-----AIR CANADA RULES-----

FOR ASSISTANCE ENROUTE DURING NORMAL BUSINESS HOURS PLEASE CONTACT OUR  
BRANCH COLLECT AT 780-425-8611 OR LOCAL MARLIN TRVL/CLUB VOYAGES OFFICE.  
WHEN CALLING OUR AFTER HOURS EMERGENCY TRVL CTRE-PLS QUOTE ACCESS CODE  
2EC0



# APPLICANT COPY

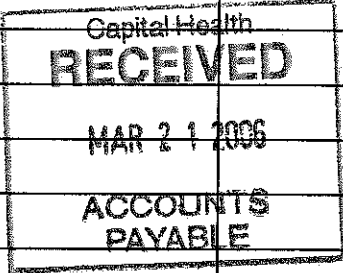
## Payment Requisition

Accounting Services  
10<sup>th</sup> Floor, North Tower CHC  
10030-107 St.  
Edmonton, Alberta T5J 3E4

<b>I PAYEE INFORMATION</b> <i>(Check one only)</i>		<input type="checkbox"/> Vendor	<input type="checkbox"/> Patient	<input checked="" type="checkbox"/> Employee (EE number <span style="border: 1px solid black; border-radius: 50%; padding: 2px;">1</span> )
Invoice Date <b>1-Nov-05</b> <i>(DD-MMM-YY)</i>	Invoice Number <span style="float: right;">s.17(1)</span>			
Vendor Number (or S.I.N.)	Payee Name <b>Dr. Gerry Predy</b>			
Address			City	
Province/State	Postal Code		Country	

<b>II PAYMENT DETAILS</b>	
Reason for payment <b>Canadian Medical Protective Association</b>	PO #
Is this a contract payment? <input type="checkbox"/> Yes <i>(Attach copy of contract if not previously forwarded)</i> <input checked="" type="checkbox"/> No	
If this is a contract payment, what is the contract date?	Number
Have goods / services been received? <input checked="" type="checkbox"/> Yes, When? <input type="checkbox"/> No	
Are original attachments to be mailed with cheque? <i>(Note 2)</i> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

<b>III EXPENSE CODES (IN ORACLE FINANCIAL SYSTEM FORMAT)</b> <span style="float: right;"><i>(Departments must provide Complete Coding)</i></span>						
Bal Unit <i>e.g. 201</i>	Location <i>e.g. 9000</i>	Functional Centre <i>e.g. 71135050044</i>	Account <i>e.g. 69500001</i>	Expense Sub-Total	GST if applicable	Total Payment
201	0007	71550300036	66020000	\$1,644.00		\$1,644.00
<input checked="" type="checkbox"/> Canadian <input type="checkbox"/> U.S. <input type="checkbox"/> Other				<b>TOTAL</b>	<b>\$1,644.00</b>	<b>\$1,644.00</b>



<b>IV AUTHORIZATION</b>	
I confirm that the above items have not been previously paid and the expenses related only to Capital Health business.	
Requisitioned by <i>(Print name)</i> <b>April Lindemann</b>	Phone # <b>413-5034</b>
<i>(Signature)</i>	Date <b>1-Mar-06</b>
Approved by <i>(Print name)</i> <b>Michele Lahey</b>	Phone # <b>407-1671</b>
<i>(Signature)</i>	Date <b>Mar 8/06</b>
Approved by <i>(Print name)</i>	Phone #
<i>(Signature)</i>	Date

**AUTHORIZATIONS SHOULD BE IN ACCORDANCE WITH SIGNING AUTHORITY POLICY NUMBER FINANCE 4.1**

- Notes:
- 1) All employee payments will be made electronically based on payroll banking information.
  - 2) All cheques and attachments will be mailed out by Accounting Services. Cheques will **NOT** be pulled and returned to departments for mailing.
  - 3) Fully completed payment requisitions received in Accounting Services by **MONDAY, 4:00 p.m.** will be processed that week.
  - 4) **Incomplete/improperly authorized payment requisitions will be returned without processing**

APPLICANT COPY

INVOICE 2006



THE CANADIAN L'ASSOCIATION  
 MEDICAL CANADIENNE  
 PROTECTIVE DE PROTECTION  
 ASSOCIATION MÉDICALE

DR GERALD PREDY  
 300-10216 124 ST NW  
 EDMONTON AB T5N 4A3

DATE: November 1, 2005

MEMBER NUMBER:

s.17(1)

**YOUR MEMBERSHIP FEES FOR THE PERIOD 01/01/2006 to 12/31/2006.**

*Based on the protection information on the accompanying Membership Update.*

REFERENCE	DATE	FEES	TAX	TOTAL
0010288065	Jan-2006	\$ 137.00	\$ 0.00	\$ 137.00
0010288065	Feb-2006	\$ 137.00	\$ 0.00	\$ 137.00
0010288065	Mar-2006	\$ 137.00	\$ 0.00	\$ 137.00
0010288065	Apr-2006	\$ 137.00	\$ 0.00	\$ 137.00
0010288065	May-2006	\$ 137.00	\$ 0.00	\$ 137.00
0010288065	Jun-2006	\$ 137.00	\$ 0.00	\$ 137.00
0010288065	Jul-2006	\$ 137.00	\$ 0.00	\$ 137.00
0010288065	Aug-2006	\$ 137.00	\$ 0.00	\$ 137.00
0010288065	Sep-2006	\$ 137.00	\$ 0.00	\$ 137.00
0010288065	Oct-2006	\$ 137.00	\$ 0.00	\$ 137.00
0010288065	Nov-2006	\$ 137.00	\$ 0.00	\$ 137.00
0010288065	Dec-2006	\$ 137.00	\$ 0.00	\$ 137.00
		<b>\$ 1,644.00</b>	<b>\$ 0.00</b>	<b>\$ 1,644.00</b>

**TOTAL 2006 FEE: \$ 1,644.00**

**YOUR PAYMENT METHOD IS: Cheque.**

*Please see reverse for instructions and other payment methods.*

*If paying by cheque, please detach and mail to: CPMA, 111*

9





# APPLICANT COPY Payment Requisition

Accounting Services  
1100 Harley Court  
10045-111 St.  
Edmonton, Alberta T5K 2M5

**I PAYEE INFORMATION (Check one only)**     Vendor     Patient     Employee (EE number)

Invoice Date Nov 25/05    Invoice Number s.17(1)

Vendor Number (or S.I.N.)    Vendor Name Dr. Gerald Pedy

Address    City

Province/State    Postal Code    Country

**II PAYMENT DETAILS**

Reason for payment College of Physicians and Surgeons license    PO #

Is this a contract payment?     Yes (Attach copy of contract if not previously forwarded)     No

If this is a contract payment, what is the contract date?    Number

Have goods / services been received?     Yes, When?     No

Are original attachments to be mailed with cheque? (Note 2)     Yes     No

**III EXPENSE CODES (IN ORACLE FINANCIAL SYSTEM FORMAT)**    (Departments must provide Complete Coding)

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050004	Account e.g. 69500000	Expense Sub-Total	GST if applicable	Total Payment
<u>201</u>	<u>0007</u>	<u>71550700036</u>	<u>66010000</u>	\$ <u>1160.00</u>	\$	\$ <u>1160.00</u>
				\$	\$	\$
				\$	\$	\$
				\$	\$	\$
				\$	\$	\$
				\$	\$	\$
				\$	\$	\$
				\$	\$	\$
				\$	\$	\$
<input checked="" type="checkbox"/> Canadian <input type="checkbox"/> U.S. <input type="checkbox"/> Other				<b>TOTAL</b>	\$ <u>1160.00</u>	\$ <u>1160.00</u>

**IV AUTHORIZATION**

I confirm that the above items have not been previously paid and the expenses related only to Capital Health business.

Requisitioned by (Print name) Dr. G. Pedy    Phone # 413-7600  
 (Signature) [Signature]    Date Nov 25/05

Approved by (Print name) Michèle Lahey    Phone # 407-1671  
 (Signature) [Signature]    Date Dec 1 '05

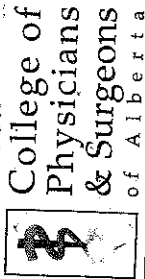
Approved by (Print name)    Phone #  
 (Signature)    Date

**AUTHORIZATIONS SHOULD BE IN ACCORDANCE WITH SIGNING AUTHORITY POLICY NUMBER FINANCE 4.1**

Notes:

- All employee payments will be made electronically based on payroll banking information.
- All cheques and attachments will be mailed out by Accounting Services. Cheques will NOT be pulled and returned to departments for mailing.
- Fully completed payment requisitions received in Accounting Services by MONDAY, 4:00 p.m. will be processed that week.
- Incomplete/improperly authorized payment requisitions will be returned without processing





College of  
Physicians  
& Surgeons  
of Alberta

900 Manulife Place  
10180-101 Street NW  
Edmonton, Alberta  
Canada T5J 4P8  
Tel: 780.423.4764  
1.800.320.8624

<b>2005 Fees</b>	<b>Receipt Number:</b>	<b>25057265</b>
<b>Date Paid:</b>	<b>Total Fees Paid:</b>	<b>\$1,160.00</b>
<b>16-Nov-2005</b>	<b>Tax Deductible Amount:</b>	<b>\$1,160.00</b>
<b>Registration #:</b>		

s.17(1)

DR. GERALD N. PREDY  
300-10216 124 ST NW  
EDMONTON AB T5N 4A3

**THIS IS YOUR RECEIPT FOR INCOME TAX PURPOSES.**

PLEASE NOTE A FEE WILL BE CHARGED FOR DUPLICATE RECEIPTS.



*Audrey P.D.*  
*in* **APPLICANT COPY**  
*Keely*  
*Revised 1/05*

Accounting Service  
10<sup>th</sup> Floor, North Tower Ct  
10030-107  
Edmonton, Alberta T5J 9S

### Payment Requisition

**I PAYEE INFORMATION** (Check one only)  Vendor  Patient  Employee (EE number)

Invoice Date *Mar 15 (DD-MMM-YY) '06* Invoice Number *Receipt # 2455534.17(1)*

Vendor Number (or S.I.N.) Payee Name *DR Gerry Pready*

Address *moth, Public Health* City \_\_\_\_\_

Province/State \_\_\_\_\_ Postal Code \_\_\_\_\_ Country \_\_\_\_\_

**II PAYMENT DETAILS** *Reimbursement Registration Fee -*

Reason for payment *Quantum Wellness Conference* PO # *Active Edmonte*

Is this a contract payment?  Yes (Attach copy of contract if not previously forwarded)  No

If this is a contract payment, what is the contract date? \_\_\_\_\_ Number \_\_\_\_\_

Have goods / services been received?  Yes, When? *Mar 10 '06*  No

Are original attachments to be mailed with cheque? (Note 2)  Yes  No

**III EXPENSE CODES (IN ORACLE FINANCIAL SYSTEM FORMAT)** (Departments must provide Complete Coding)

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Expense Sub-Total	GST if applicable	Total Payment
<i>201</i>	<i>0007</i>	<i>71550300036</i>	<i>61030000</i>	<i>133.75</i>		<i>133.75</i>
<div style="border: 1px solid black; padding: 5px; display: inline-block;">           Capital Health <b>RECEIVED</b> MAR 27 2006 ACCOUNTS PAYABLE         </div> <div style="border: 1px solid black; padding: 5px; display: inline-block; margin-left: 20px;">           Capital Health <b>RECEIVED</b> MAR 21 2006 ACCOUNTS PAYABLE         </div>						
<input type="checkbox"/> Canadian <input type="checkbox"/> U.S. <input type="checkbox"/> Other					<b>TOTAL</b>	<i>\$133.75</i>

**IV AUTHORIZATION**

I confirm that the above items have not been previously paid and the expenses related only to Capital Health business.

Requisitioned by (Print name) *Bernadine Paterson* Phone # *413 - 5070*

(Signature) *[Signature]* Date *Mar 15 '06*

Approved by (Print name) \_\_\_\_\_ Phone # *413 - 7600*

(Signature) *[Signature]* Date \_\_\_\_\_

Approved by (Print name) *Michelle Lahey* Phone # *407-1671*

(Signature) *Gert Frue for M. Lahey* Date *MAR 24 2006*

**AUTHORIZATIONS SHOULD BE IN ACCORDANCE WITH SIGNING AUTHORITY POLICY NUMBER FINANCE 4.1**

Notes:  
 1) All employee payments will be made electronically based on payroll banking information.  
 2) All cheques and attachments will be mailed out by Accounting Services. Cheques will NOT be pulled and returned to departments for mailing.  
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*[Handwritten mark]*

City of Edmonton - Community Services

Capital Health  
 Gerry Predy  
 300 10216 124 Street  
 Edmonton, AB T5N 4A3

Receipt #: 2455534  
 User: balhar  
 Issued: Fri 10 Mar 06 11:07 am

Description	Amount
Previous Balance	\$0.00
Registration: Gerry Predy #205099 : HNUT - WINTER 2006 - 001	\$125.00

Classes: 1 Active Living @ work! Hours: 7:30 Days: Thu  
 Starts: Thu 16 Mar 06 09:00 am - 04:30 PM  
 Ends: Thu 16 Mar 06 09:00 am - 04:30 PM  
 Location: Manulife Centre - Kwantum Wellness Conference

Goods & Services Tax 21 \$8.75

Payment: Visa Card Front Desk (\$133.75)

Balance \$0.00

Community Services

Community Services

The personal information collected from you is collected under the authority of S. 33(c) of the Freedom of Information and Protection of Privacy Act and will be used to administer program registrations, membership management and facility bookings for Community Services. Aggregate data will be used for program planning and evaluation. Questions about the collection of personal information should be directed to the Community Services FOIP Coordinator at 496-4999.

APPLICANT COPY

Gerald Predy  
 CLASS 207099  
 413-7946

EASTBLEN POOL  
 11426 68 ST  
 EDMONTON AB T5J4R1  
 22904316

City of Edmonton - Community Services  
 Recreation Facility Services

PLU#: Balance Forward 0.00 0.00  
 PLU#: Registration - Predy, Gerry : #203099 :  
 MNCT - 2006 WINTER - 001 125.00 125.00tx  
 SubTotal: 125.00  
 GST 9.75  
 Total: 133.75

Visa Card  
 Front Desk 133.75  
 (Account:Capital Health)  
 3/10/2006 11:09 balhar  
 #2231879 /2005/18

SERVING YOU IN YOUR COMMUNITY  
 Community Services Info - 496-4989  
 www.edmonton.ca/comm\_services/  
 Register for Community Services Programs  
 and Courses online!  
 Visit www.edmonton.ca and click on eReg.  
 GST NR119326270 RT 0001

Name: s.17(1), 17(4)(e.1)  
 Acct #  
 Date 06/03/10 Time 11 07 55  
 Exp Date Auth # 045708  
 Card Type VI Tran Code 00  
 #22904316001 00162001

Invoice No.: 1100  
 Subtotal \_\_\_\_\_  
 Tax \_\_\_\_\_  
 Total \$133.75

Signature X *Phone order*  
 I agree to pay above total amount  
 according to card issuer agreement  
 Retain this copy for your records

Top copy-customer Bottom copy-merchant



# APPLICANT COPY

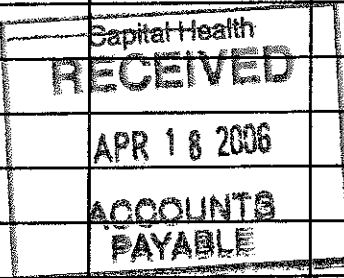
Accounting Services  
10<sup>th</sup> Floor, North Tower CHC  
10030-107 St.  
Edmonton, Alberta T5J 3E4

## Payment Requisition

<b>I PAYEE INFORMATION</b> (Check one only)		<input type="checkbox"/> Vendor	<input type="checkbox"/> Patient	<input checked="" type="checkbox"/> Employee (EE number)
Invoice Date <i>10 April 06</i> (DD-MMM-YY)	Invoice Number			
Vendor Number (or S.I.N.)	Payee Name <i>Dr. G Predy</i>			s.17(1)
Address			City	
Province/State	Postal Code	Country		

<b>II PAYMENT DETAILS</b>	
Reason for payment <i>Reimbursement - CPAA Conference Reg.</i>	PO #
Is this a contract payment?	<input type="checkbox"/> Yes (Attach copy of contract if not previously forwarded) <input checked="" type="checkbox"/> No
If this is a contract payment, what is the contract date?	Number
Have goods / services been received?	<input checked="" type="checkbox"/> Yes, When? <input type="checkbox"/> No
Are original attachments to be mailed with cheque? (Note 2)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

III EXPENSE CODES (IN ORACLE FINANCIAL SYSTEM FORMAT)						(Departments must provide Complete Coding)	
Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Expense Sub-Total	GST if applicable	Total Payment	
<i>201</i>	<i>0007</i>	<i>71550300036</i>	<i>61030000</i>	<i>490.00</i>		<i>490.00</i>	
<input checked="" type="checkbox"/> Canadian <input type="checkbox"/> U.S. <input type="checkbox"/> Other				<b>TOTAL</b>	<i>490.00</i>		<i>490.00</i> ✓



<b>IV AUTHORIZATION</b>	
I confirm that the above items have not been previously paid and the expenses related only to Capital Health business.	
Requisitioned by (Print name)	<i>Lavera Sebulyk</i>
(Signature)	<i>Lavera Sebulyk</i>
Approved by (Print name)	<i>Michele Lakey</i>
(Signature)	<i>Michele Lakey</i>
Approved by (Print name)	
(Signature)	
Phone #	<i>413-7946</i>
Date	<i>18-Feb-06</i>
Phone #	<i>4071671</i>
Date	<i>Apr 11/06</i>
Phone #	
Date	

**AUTHORIZATIONS SHOULD BE IN ACCORDANCE WITH SIGNING AUTHORITY POLICY NUMBER FINANCE 4.1**

Notes:

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- Incomplete/improperly authorized payment requisitions will be returned without processing

APPLICANT COPY



Canadian Public Health Association

Association canadienne de santé publique

**RECEIPT**

Suite 400  
1565 Carling Avenue  
Ottawa, ON K1Z 8R1  
Fax: 613-725-9826

Date	Receipt No.
03-27-2006	A003254

Payer:

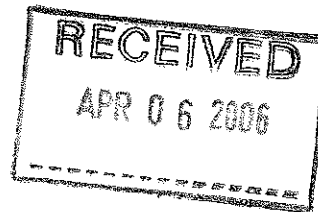
---

Gerry N Predy  
#300 10216 - 124 Street  
Edmonton, AB, T5N 4A3 Canada

Inv No.	Description	Total Fees	Tax	Applied Amount
A0003577	Registration for Gerry Predy for the event: CPHA 97th Annual Conference - *Full Conference Package / Forfait conférence	490.00	0.00	490.00

Visa:  s.17(1), 17(4)(e.1)	<b>Total Fees w/Tax</b>	490.00
	<b>Total Paid</b>	490.00
	<b>Total Applied</b>	490.00
	<b>Unapplied Balance</b>	0.00

Thank you for your payment received on 03-27-2006.



APPLICANT COPY



Canadian Public Health Association      Association canadienne  
de santé publique

Suite 400, 1565 Carling Avenue  
Ottawa, Ontario  
K1Z 8R1  
Tel: (613) 725-3769 Fax: (613) 725-9826

March 27, 2006

Dr. Gerry N Predy  
VP Public Health and Medical Officer of Health  
Capital Health - Edmonton  
#300 10216 - 124 Street  
Edmonton, AB T5N 4A3

Dear Dr. Predy:

We are pleased that you will be attending the CPHA 97th Annual Conference to be held at the Fairmont Hotel Vancouver in Vancouver from May 28-31, 2006.

We would like to confirm your registration information. You are registered for:

\*Full Conference Package / Forfait conférence **\$490.00**

NSSCM Annual General Meeting (NSSCM members only) **\$0.00**

Your payment information is as follows:	Total Cost:	<b>\$490.00</b>
	Paid:	<b>\$490.00</b>

A separate email will be sent to you with your receipt. Should you have any questions or concerns, please contact me either by telephone at (613) 725-3769 ext. 126 or by e-mail at [grobert@cpha.ca](mailto:grobert@cpha.ca).

We look forward to seeing you in Vancouver.

Sincerely,

Gisèle Robert  
Conference Department



# APPLICANT COPY

## Payment Requisition

Accounting Services  
10<sup>th</sup> Floor, North Tower CHC  
10030-107 St.  
Edmonton, Alberta T5J 3E4

<b>I PAYEE INFORMATION</b> (Check one only)		<input type="checkbox"/> Vendor	<input type="checkbox"/> Patient	<input checked="" type="checkbox"/> Employee (EE number)		
Invoice Date (DD-MMM-YY)	Invoice Number			s.17(1)		
Vendor Number (or S.I.N.)	Payee Name <i>Dr. G. Predy</i>					
Address			City			
Province/State	Postal Code		Country			
<b>II PAYMENT DETAILS</b>						
Reason for payment <i>Conference Registration</i>			PO #			
Is this a contract payment?			<input type="checkbox"/> Yes (Attach copy of contract if not previously forwarded) <input checked="" type="checkbox"/> No			
If this is a contract payment, what is the contract date?			Number			
Have goods / services been received? <input checked="" type="checkbox"/> Yes. When? <i>18 Feb 06</i>			<input checked="" type="checkbox"/> No			
Are original attachments to be mailed with cheque? (Note 2)			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
<b>III EXPENSE CODES (IN ORACLE FINANCIAL SYSTEM FORMAT)</b> (Departments must provide Complete Coding)						
Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Expense Sub-Total	GST if applicable	Total Payment
<i>201</i>	<i>0007</i>	<i>71550300036</i>	<i>61030000</i>	<i>40.00</i>		<i>40.00</i>
			<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: auto;"> Capital Health  <b>RECEIVED</b>  MAY 17 2006  ACCOUNTS  PAYABLE </div>			
<input checked="" type="checkbox"/> Canadian <input type="checkbox"/> U.S. <input type="checkbox"/> Other			<b>TOTAL</b>	<i>40.00</i>		<i>40.00</i>
<b>IV AUTHORIZATION</b>						
I confirm that the above items have not been previously paid and the expenses related only to Capital Health business.						
Requisitioned by (Print name) <i>Lavera Sebulska</i>			Phone # <i>413-794.6</i>			
(Signature) <i>Lavera Sebulska</i>			Date <i>18-Feb-06</i> <i>Apr 27/06</i>			
Approved by (Print name) <i>Michele Cahay</i>			Phone # <i>407-1671</i>			
(Signature) <i>Michele Cahay</i>			Date <i>28 April 06</i>			
Approved by (Print name)			Phone #			
(Signature)			Date			
<b>AUTHORIZATIONS SHOULD BE IN ACCORDANCE WITH SIGNING AUTHORITY POLICY NUMBER FINANCE 4.1</b>						
Notes:						
1) All employee payments will be made electronically based on payroll banking information.						
2) All cheques and attachments will be mailed out by Accounting Services. Cheques will NOT be pulled and returned to departments for mailing.						
3) Fully completed payment requisitions received in Accounting Services by <b>MONDAY, 4:00 p.m.</b> will be processed that week.						
4) Incomplete/improperly authorized payment requisitions will be returned without processing						



## APPLICANT COPY

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 Timewise Event Management Inc.
 

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**Official Conference Receipt**

**Gerry Predy**  
**Capital Health**  
 #300 10216 - 124 Street  
 Edmonton, AB Canada T5N 4A3

**Confirmation Number:** 3026619**Date:** 2006Apr26

Registrant	Description	Total
Gerry Predy	Delegate Registration \$40 - APHA/AHLN Member (Jun. 06, 2006)	\$40.00 CAD
<b>Total</b>		<b>\$40.00 CAD</b>
	Your credit card payment was approved. VISA Cardholder: Gerald Predy	\$40.00 CAD <sup>CT</sup>
<b>CAD Dollars Owing</b>		<b>\$0.00 CAD</b>

Please **print and keep this conference receipt** as confirmation of your online payment. To discuss your account please contact Timewise Events Management Inc. or send an email to: [apha@timewiseevents.com](mailto:apha@timewiseevents.com).

Alberta Public Health Association - GST Registration #XXX

Timewise Event Management Inc.  
 456, 17008 - 90 Avenue NW  
 Edmonton, Alberta T5T 1L6  
 Canada  
 phone: 780-444-3773  
 fax: 780-444-6776

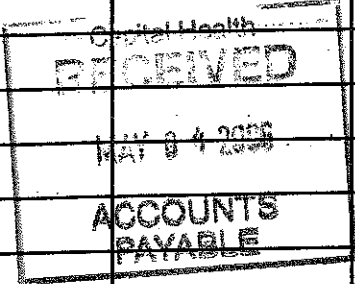


# APPLICANT COPY

Accounting Services  
10<sup>th</sup> Floor, North Tower CHC  
10030-107 St.  
Edmonton, Alberta T5J 3E4

## Payment Requisition

<b>I PAYEE INFORMATION (Check one only)</b>		<input type="checkbox"/> Vendor	<input type="checkbox"/> Patient	<input checked="" type="checkbox"/> Employee (EE number)		
Invoice Date (DD-MMM-YY)	Invoice Number			s.17(1)		
Vendor Number (or S.I.N.)	Payee Name <i>Dr. G. Predy</i>					
Address				City		
Province/State	Postal Code	Country				
<b>II PAYMENT DETAILS</b>						
Reason for payment <i>Conference Registration</i>				PO #		
Is this a contract payment? <input type="checkbox"/> Yes (Attach copy of contract if not previously forwarded) <input checked="" type="checkbox"/> No						
If this is a contract payment, what is the contract date?				Number		
Have goods / services been received? <input type="checkbox"/> Yes, When? <input checked="" type="checkbox"/> No						
Are original attachments to be mailed with cheque? (Note 2) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
<b>III EXPENSE CODES (IN ORACLE FINANCIAL SYSTEM FORMAT) (Departments must provide Complete Coding)</b>						
Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Expense Sub-Total	GST if applicable	Total Payment
<i>201</i>	<i>0007</i>	<i>71550300036</i>	<i>61030000</i>	<i>40.00</i>		<i>40.00</i>
<input checked="" type="checkbox"/> Canadian	<input type="checkbox"/> U.S.	<input type="checkbox"/> Other	<b>TOTAL</b>	<i>40.00</i>		<i>40.00</i>
<b>IV AUTHORIZATION</b>						
I confirm that the above items have not been previously paid and the expenses related only to Capital Health business.						
Requisitioned by (Print name) <i>Lavera Sebulsky</i>				Phone # <i>413-7946</i>		
(Signature) <i>Lavera Sebulsky</i>				Date <i>18-Feb-06</i> <i>Apr 27/06</i>		
Approved by (Print name) <i>Michele Cahay</i>				Phone # <i>407-1671</i>		
(Signature) <i>Michele Cahay</i>				Date <i>28 April 06</i>		
Approved by (Print name)				Phone #		
(Signature)				Date		
<b>AUTHORIZATIONS SHOULD BE IN ACCORDANCE WITH SIGNING AUTHORITY POLICY NUMBER FINANCE 4.1</b>						
Notes:						
1) All employee payments will be made electronically based on payroll banking information.						
2) All cheques and attachments will be mailed out by Accounting Services. Cheques will NOT be pulled and returned to departments for mailing.						
3) Fully completed payment requisitions received in Accounting Services by MONDAY, 4:00 p.m. will be processed that week.						
4) Incomplete/improperly authorized payment requisitions will be returned without processing						



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**Timewise Event Management Inc.**


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## Official Conference Receipt

**Gerry Predy**  
**Capital Health**  
**#300 10216 - 124 Street**  
**Edmonton, AB Canada T5N 4A3**

**Confirmation Number: 3026619**

**Date: 2006Apr26**

Registrant	Description	Total
Gerry Predy	Delegate Registration \$40 - APHA/AHLN Member (Jun. 06, 2006)	\$40.00 CAD
<b>Total</b>		<b>\$40.00 CAD</b>
	Your credit card payment was approved. VISA Cardholder: Gerald Predy	\$40.00 <sup>cr</sup> CAD
<b>CAD Dollars Owing</b>		<b>\$0.00 CAD</b>

Please print and keep this conference receipt as confirmation of your online payment. To discuss your account please contact Timewise Events Management Inc. or send an email to: [apha@timewiseevents.com](mailto:apha@timewiseevents.com).

Alberta Public Health Association - GST Registration #XXX

Timewise Event Management Inc.  
 456, 17008 - 90 Avenue NW  
 Edmonton, Alberta T5T 1L6  
 Canada  
 phone: 780-444-3773  
 fax: 780-444-6776



# APPLICANT COPY

Accounting Services  
10<sup>th</sup> Floor, North Tower CHC  
10030-107 St.  
Edmonton, Alberta T5J 3E4

## Payment Requisition

<b>I PAYEE INFORMATION</b> (Check one only)		<input type="checkbox"/> Vendor	<input type="checkbox"/> Patient	<input checked="" type="checkbox"/> Employee
Invoice Date <b>May 2</b> (DD-MMM-YY) <b>06</b>	Invoice Number <b>174097</b>	s.17(1)		
Vendor Number (or S.I.N.)	Payee Name <b>DR Gerry Predy</b>			
Address <b>Plaza 124, 10216-124st, Suite 300</b>	City <b>EDMONTON</b>			
Province/State <b>AB</b>	Postal Code <b>T6J 3Y2</b>	Country		

<b>II PAYMENT DETAILS</b>	
Reason for payment <b>Reimbursement - CH Member tickets</b>	
Is this a contract payment? <input type="checkbox"/> Yes (Attach copy of contract if not previously forwarded) <input checked="" type="checkbox"/> No	
If this is a contract payment, what is the contract date?	Number
Have goods / services been received? <input type="checkbox"/> Yes, When? <input checked="" type="checkbox"/> No	
Are original attachments to be mailed with cheque? (Note 2) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

<b>III EXPENSE CODES (IN ORACLE FINANCIAL SYSTEM FORMAT)</b>						(Departments must provide Complete Coding)	
Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Expense Sub-Total	GST if applicable	Total Payment	
<b>001</b>	<b>0007</b>	<b>71550300003</b>	<b>61030000</b>			<b>35.00</b>	
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;">           Capital Health  <b>RECEIVED</b>             MAY 17 2006             ACCOUNTS            PAYABLE         </div>							
<input type="checkbox"/> Canadian		<input type="checkbox"/> U.S.		<input type="checkbox"/> Other		<b>TOTAL</b>	
						<b>\$ 35.00</b>	

<b>IV AUTHORIZATION</b>	
I confirm that the above items have not been previously paid and the expenses related only to Capital Health business.	
Requisitioned by (Print name) <b>Bernadine Paterson</b>	Phone # <b>413 - 5070</b>
(Signature)	Date <b>May 2 '06</b>
Approved by (Print name) <b>Dr. Gerry Predy</b> <b>Michele Lahey</b>	Phone # <b>413-7600 467-8884</b>
(Signature)	Date
Approved by (Print name)	Phone #
(Signature)	Date

**AUTHORIZATIONS SHOULD BE IN ACCORDANCE WITH SIGNING AUTHORITY POLICY NUMBER FINANCE 4.1**

Notes:

- 1) All employee payments will be made electronically based on payroll banking information.
- 2) All cheques and attachments will be mailed out by Accounting Services. Cheques will NOT be pulled and returned to departments for mailing.
- 3) Fully completed payment requisitions received in Accounting Services by **MONDAY, 4:00 p.m.** will be processed that week.
- 4) Incomplete/improperly authorized payment requisitions will be returned without processing



**EDMONTON**  
**CHAMBER OF COMMERCE**

700 - 9990 Jasper Avenue,  
World Trade Centre Edmonton  
Edmonton, Alberta Canada T5J 1P7

**Invoice**

Organization #: 5667

Dr. Gerry Predy  
Capital Health  
300-10216 124 Street  
Edmonton, AB T5N 4A3

Date: 04/21/2006  
Invoice #: 174097  
Due: 05/22/2006

Description	Quantity	Rate	Amount
Capital Health Breakfast Member Tickets	1	32.71	32.71
GST - Events/Services	1	2.29	2.29
		Amount:	35.00
		Payments:	-35.00
		Balance:	0.00

EDMONTON CHAMBER OF  
COMMERCE  
9990 JASPER AVENUE SUITE  
EDMONTON AB  
CARD  
CARD TYPE VISA  
DATE 2006/04/21  
TIME 13:55:01  
INVOICE # 174097  
RCPT # M15401222-001-520

s.17(1), 17(4)(e.1)

**GST REGISTRATION NO. 107282196 RT**

*Further Information Contact Accounts Receivable at 780.426.4620*

*Keep this portion for your records  
Please return this portion with your payment*

PURCHASE  
TOTAL \$35.00

01 APPROVED 027  
AUTH# 041890  
THANK YOU

Dr. Gerry Predy  
Capital Health  
300-10216 124 Street  
Edmonton, AB T5N 4A3

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