

<b>Bursar to Complete:</b>	Batch #: _____
Check No.: _____	Date: _____
Amount: \$ _____	_____

**UNIVERSITY OF CONNECTICUT HEALTH CENTER  
TRAVEL ADVANCE REQUEST FORM**

**FORM MUST BE TYPED**

Please complete sections A and B and forward to Bursar's Office, ASB MC 5105.

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**Section A:**

Traveler's Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
 Department: \_\_\_\_\_ Mail Code: \_\_\_\_\_ Phone: \_\_\_\_\_  
 TA Number: \_\_\_\_\_ Destination: \_\_\_\_\_ Depart Date: \_\_\_\_\_ Return Date: \_\_\_\_\_

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**Section B:**

AMOUNT REQUESTED may be up to 75% of the Total Other Costs on TA Request:  
**Note:** Please be sure NOT to include airfare or registration in the amount requested.

AMOUNT REQUESTED: \$ \_\_\_\_\_

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**Section C:**

**PROMISSORY NOTE**

For value received, I \_\_\_\_\_ promise to pay to the order of the University of Connecticut Health Center, on demand, the sum of \$ \_\_\_\_\_, said amount representing an advance to me.

I agree that within five (5) working days after my return, I will submit a completed Request for Reimbursement of Expenses, with the required documentation, to the General Accounting Department, MC 5305.

I also agree, if these conditions are not met, that this amount may be deducted from my paycheck, or other monies due me at the time, and in the manner Health Center Officials deem necessary and appropriate. I also understand that future advances may be withheld if I do not comply.

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**Section D: (To be completed when check is received)**

I hereby acknowledge and agree to the above:

Traveler's Signature: \_\_\_\_\_ DATE: \_\_\_\_\_