WRHA - MEDICAL REMUNERATION AD - HOC SUBMISSION FORM

PROGRAM: PRIMARY CARE

PHYSICIAN NAME: _____

SITE ADDRESS: _____

Aikins	Access Downtown	Access Ft Garry

ARE	AT	AWW	Locum

START DATE: _____ **STEP** _____

END DATE: _____ **CLASS** _____

PAY DATE: _____

	PHYSICIAN DETAIL:					
DATE(S) WORKED eg MMM/DD/YY	LAST NAME	FIRST NAME	RATE OF PAY	UNIT OF PAY eg day/hr/wk	# OF UNITS	AMOUNT PAID
						0.00
						0.00
						0.00
						0.00
						0.00
						0.00
						0.00
						0.00
						0.00
						0.00
						0.00
						0.00
						0.00
						0.00
						0.00
					TOTAL:	0.00

SUBMITTED BY: _____

PHONE: _____

APPROVED BY: _____

AUTHORIZED BY: _____

RETURN TO: MEDICAL REMUNERATION
WRHA-Finance
4th Flr-650 Main Street
E-MAIL: WRHA_ADHOC@wrha.mb.ca
FAX: 204-940-1792
PH: 204-926-7160