**Massachusetts Association of Public Health Nurses**

**TRAVEL AGREEMENT**

Date:

I,       , agree to comply with the MAPHN travel guidelines for out-of-state travel. Should I, for whatever reason, be unable to complete the MAPHN funded travel, I agree to reimburse the organization in a timely manner for any expenses incurred. Exceptions to this agreement will only be made with signed consent from the MAPHN Executive Board.

Applicant Name:

Address:

Telephone:

Email:

Chapter affiliation:

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

**This completed form should be mailed to:**

**MAPHN**

**Caroline Kinsella**

**PO Box 537**

**Milton, MA 02186**

Public Health Nurses making a difference … improving and protecting the health of communities

www.maphn.org