Northeast Indiana AHEC Travel Reimbursement Grant

Eligibility Information
2026-2027 Program Year

- You are eligible for the NEI Clinical Travel Grant if you are a post-secondary health professions student in the NEI region (Allen, DeKalb, Elkhart, Kosciusko, LaGrange, Noble, Steuben & Whitley counties), and you are required to travel to an off-campus clinical site for patient care experiences.

- You must travel 715 miles or more to be eligible for a $400.00 reimbursement award.

- **Travel grant reimbursements are disbursed on a first-come first-served basis as we receive completed paperwork. If funding is depleted at the time of your submission, you will be notified that awards are no longer available.**

- **Eligible travel dates:** Only travel that **occurs between July 1, 2026 and June 30, 2027** is eligible for reimbursement. Travel outside of these dates cannot be reimbursed.

- **Application timing:** You may submit **one reimbursement application per AHEC program year**.

- You cannot submit for reimbursement in advance of dates you have not traveled.

- You are ineligible for funding if your clinical site is outside of Indiana or your clinical site is at your university.

- You may not request reimbursement for any travel other than your clinical rotation site. Travel to classes, conferences, etc. is not eligible.

- Your clinical site supervisor **must** sign off on the attached travel log. Copied/pasted signatures will not be accepted. **The supervisor signature must be handwritten.**

- **Please submit this form, including the completed clinical travel log for each clinical site to NEI-AHEC at neiahec@goshen.edu. Please submit all forms together in a single PDF file. Reimbursement will be processed once you have completed the required AHEC evaluation (this will be emailed to you).**

- Below please provide your name, address, and signature that you have read and understand the grant eligibility and submission requirements. **Provide the address that is used in your mileage calculation.*

Student Name _____

Street Address _____

City, State, Zip Code _____

Academic Program _____

College/University _____

I have read the eligibility rules & requirements and certify that the information provided on the travel log is correct.

Student Signature_____ **Date**_____

Reimbursement Payment Method

Payment Method (select one):

☐ Check (mailed)
☐ Venmo

If you selected Check - please indicate where you would like your reimbursement check mailed:

☐ Mail to the address provided on Page 1

☐ Mail to an alternate address (complete below)

Name: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

**Please ensure the address provided is complete and accurate. NEI-AHEC is not responsible for delays resulting from incorrect or incomplete mailing information.*

If you selected Venmo:

Please provide the following information:

Venmo Username (@username): _____

Name on Venmo Account: _____

Phone Number or Email Associated with Venmo Account (for verification):_____

Important Information

Standard Transfer (No Fee) – Funds are typically available within 2–3 business days.

Instant Transfer (Fee Applies) – Funds are typically available immediately or within minutes. Any fees charged by the payment platform for instant transfer services are the responsibility of the recipient and may reduce the amount received.

Acknowledgment:
By selecting the Instant Transfer option, I understand that any fees associated with expedited payment processing are my responsibility and are not reimbursable by NEI-AHEC.

By selecting Venmo, you certify that the Venmo account information provided is accurate and belongs to you. NEI-AHEC is not responsible for payments sent to an incorrect Venmo account due to inaccurate information submitted on this application. Once a Venmo payment has been successfully sent to the account provided, the reimbursement will be considered paid in full.

- Reimbursements will not be processed until all required documentation has been received and approved.
- Processing times may vary based on the payment method selected.
- NEI-AHEC reserves the right to issue payment by check if there are issues processing a Venmo payment.
- Applicants are responsible for ensuring all payment information is accurate and current at the time of submission.

Student Signature_____ **Date** _____

Interprofessional Clinical Rotation Experience

As part of this clinical rotation, please indicate whether you worked alongside students enrolled in other health professions programs.

Please provide **only aggregate information**. **Do not include student names, school names, or any personally identifiable information.**

Below please indicate the number of students from other health professions disciplines with whom you interacted or collaborated during your rotation:

Health Professions Program	Number of Students Worked With
Medicine (MD/DO)	_____
Nursing	_____
Physician Assistant	_____
Pharmacy	_____
Physical Therapy	_____
Occupational Therapy	_____
Social Work	_____
Behavioral / Mental Health	_____
Public Health	_____
Other (please specify): _____	_____
Other (please specify): _____	_____

☐ I did not work with students from other health professions programs during this clinical rotation.

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Student Clinical Travel Log

Clinic Name/Full Address					
Clinic Name: Street Address: City, State, Zip+4 Code: County:					
Dates of Clinical Rotations					
Total number of trips to this site:	**Total number of hours spent at this site:**		***Round trip miles traveled daily:**		**Total miles traveled to this clinical site:**

Round trip miles (round trip = start point to clinic and back to the start point). ***Do NOT round mileage.*** *We need exact miles traveled to the tenth of a mile. For example, if your round trip is 45.6 miles, use this figure in calculating total miles traveled to the site.*

I certify that the student above completed the clinical rotation as reported.

Clinical Supervisor Name – PLEASE PRINT_____

Clinical Supervisor Signature_____ **Date**_____

Clinic Name/Full Address					
Clinic Name: Street Address: City, State, Zip+4 Code: County:					
Dates of Clinical Rotations					
Total number of trips to this site:	**Total number of hours spent at this site:**		***Round trip miles traveled daily:**		**Total miles traveled to this clinical site:**

Round trip miles (round trip = start point to clinic and back to the start point). ****Do NOT round mileage.*** *We need exact miles traveled to the tenth of a mile. For example, if your round trip is 45.6 miles, use this figure in calculating total miles traveled to the site.*

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Clinical Supervisor Name – PLEASE PRINT_____

Clinical Supervisor Signature_____ **Date**_____

Clinic Name/Full Address					
Clinic Name: Street Address: City, State, Zip+4 Code: County:					
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Clinical Supervisor Name – PLEASE PRINT_____

Clinical Supervisor Signature_____ **Date**_____