WRHA - MEDICAL REMUNERATION AD - HOC SUBMISSION FORM
(Do not fill in shaded area)

PROGRAM: **Primary Health Care**

SUB PROGRAM: **Locum Program**

HOSPITAL:

POSITION TITLE: **Locum Physician**

START DATE:

END DATE:

PAY DATE:

Only One line per Physician

PHYSICIAN DETAIL:					
LAST NAME	FIRST NAME	RATE OF PAY	UNIT OF PAY eg day/hr/wk	# OF UNITS	AMOUNT PAID
					$0.00
			hr		$0.00
			hr		$0.00
			hr		$0.00
			TOTAL:		$0.00

Submitted by: Brooklyn Roberge

Phone : 204-940-8734

RETURN TO:
MEDICAL REMUNERATION
WRHA-Finance
4th Flr-650 Main Street
E-MAIL: WRHA_ADHOC@wrha.mb.ca
FAX: 940-1792
PH: 926-7161