

**MASSACHUSETTS GENERAL HOSPITAL
Department of Nursing**

CERTIFICATION/RECERTIFICATION: DEMETRI SOURETIS FUND

FEES REIMBURSEMENT REQUEST

Name _____ **Unit No.** _____

Job Title _____ **Unit** _____

Social Security/ Tax ID number _____

Name of Certifying Nursing Organization _____

Type of Certification _____

Date of Examination _____ **Cost** _____

Employee Signature _____ **Date** _____

**Nurse Manager/Director
Signature** _____ **Date** _____

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1. **Attach documentation that you have taken the exam.**
 2. **Attach cancelled check or valid receipt for the exam.**
 3. **Submit Request to PCS Management Systems Office Attn: Demetri Souretis Fund, GRB 1034.**
 4. **Per Accounts Payable all checks will be mailed directly to your home address.**

Please mail my check to the address below:

(Address)

(City and State)

(Zip Code)