Service Provider Out of State Travel Request

| Travel details: |
| --- |
| Service Provider: |  | Contact: |  |
| Phone: |  | Contact email: |  |
| Event name: |  |
| Event location:  |  | Event date(s): |  |
| Award ID(s): |  | Est. Total Travel Cost: |  |
|  |  | EAP portion of Cost: |  |

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| --- |
| Attendee names and titles:  |

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| --- |
| Event description:  |

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| Explain purpose of attendance, how EAP benefits, and how this information and knowledge will be shared with others:  |
|  |  |  |
| Service Provider Executive Director Signature |  | Date |
|  |  | **Submit to**: eap.mail@state.mn.us  |
| Typed Service Provider Executive Director Name |  |  |
| Department of Commerce EAP Director ApprovalBy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |