NOTE: Must Print in LANDSCAPE format

EXPENSE FORM

Name:	Purpose of Trip or Expense:
Mail Check To:	
City, State, Zip	

A	DAY >>								TOTALS
	DATE >>								
	FROM >>>>>								BE SURE TO INCLUDE ALL ORIGINAL REQUIRED RECEIPTS
	TO >>>>>>								
Trip Expenses	PERSONAL CAR MILEAGE: _____								
	@ .445/MILE =								
	PARKING, TOLLS, STORAGE FEES								
	CAR RENTAL - Number of Conference Days Plus 1 Day Only								
	CABS, LOCAL FARES								
	AIR								
	LODGING								
	MEALS: $75 PER DAY	ENTER NUMBER OF DAYS OF CONFERENCE PLUS 1 DAY IN BOX TO THE RIGHT >>>>>>>>				X	$75.00		
	WEEKLY TOTAL >>>								
	MISCELLANEOUS								
MISCELLANEOUS									
	MISCELLANEOUS TOTAL >>>								

NOTE: ORIGINAL RECEIPTS, ONLINE CONFIRMATIONS AND/OR EMAIL CONFIRMATIONS ARE REQUIRED. CREDIT CARD STATEMENTS ARE NOT ACCEPTABLE.

Grand Total >>

SIGNATURE IS REQUIRED FOR PROCESSING. UNSIGNED FORMS WILL BE RETURNED, WHICH WILL DELAY PROCESSING OF YOUR REIMBURSEMENT.

I certify that all of the claimed expenses reflected on this expense report were incurred for the direct benefit of the company and/or directly benefited my medical education and practice and constitute ordinary and necessary business expenses of the company as defined by the Internal Revenue Code and Regulations.

Employee:	Date:

APPROVAL SIGNATURE

Regional Medical Director:	Date:

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VENDOR No._____ VENDOR ID:_____

COID:	DEPT. #	Amount
	TOTAL >	

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PDA Purchased Year: _____	Maximum Allowable Amount: _____
	Reimbursed Amount: _____
Replacement Year: _____	Available Amount: _____

EFFECTIVE DATE: 2-16-2005