# Travel Reimbursement Form

**Payee Name:** _____ **DATE** _____

**Payee Address:** _____

_____

_____

**INSTRUCTIONS:**
1) Return this form within 30 DAYS of event
2) Attach ALL ORIGINAL RECEIPTS (Copies NOT accepted)
3) Sign form and confirm mailing address for payment

*Return to:*

**Shanna Castro**
California Rheumatology Alliance
5230 Pacific Concourse Dr. #100
Los Angeles, CA 90045

**Description:** Reimbursement for ACR trip

| LOCATION (To/From) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **DATES** | | | | | | | | **Amount** |
| **AIRFARE** | | | | | | | | 0.00 |
| **GROUND TRANSPORTATION** | | | | | | | | 0.00 |
| **MILEAGE ($.54 per mile)** | | | | | | | | 0.00 |
| **HOTEL (less personals)** | | | | | | | | 0.00 |
| **MEALS (outside of event)** | | | | | | | | 0.00 |
| **DUES/SUBSCRIPTIONS** | | | | | | | | 0.00 |
| **GIFTS** | | | | | | | | 0.00 |
| **MISCELLANEOUS** | | | | | | | | $ - |
| | | | | | | | | |
| | | | | | | **Total:** | | $0.00 |

**By signing below, I certify that this statement is accurate and to actual and necessary business expenses**

5/24/2018
Requested By: Date

**By signing below, I certify that I have reviewed these claims and find it to be reasonable and in compliance with the established policy and misison of the practice**

5/24/2018
Approval: Shanna Castro/ Executive Director Date

FOR ACCOUNTING USE ONLY: