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: