EDWIN FAIR COMMUNITY MENTAL HEALTH CENTER

***REQUEST FOR MEETING ADVANCE***

*All advances require pre-approval from supervisors at $30/per diem (day)*

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Request:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Meeting:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of Meeting:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date(s) of Meeting:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Original receipts must be submitted to Accounts Payable within (10) days. Any advances that were not reconciled within the time given will be deducted from your next expense reimbursement or payroll. If an extension is needed, please notify your supervisor and Accounts Payable prior to the deadline.

***ESTIMATED EXPENSES:***

|  |  |
| --- | --- |
| Registration Fees: |  |
| Lodging: |  |
| Meals: |  |
| Miles \_\_\_\_\_\_\_\_\_ x 0.535 |  |
| Air Fair / Auto Rental:  |  |
| Tolls / Parking: |  |

Total: [Net Amount of Advance]:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing this form, I authorize Edwin Fair Community Mental Health Center Inc. to deduct from my next expense reimbursement or payroll if I fail to submit original receipts after the allowed number of days (10).

Employee Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Once approved and processed, you will be issued a check advance (2) days prior to your training*

|  |
| --- |
| **ACCOUNT DISTRIBUTION – FOR ADMINISTRATIVE USE ONLY** |
| Vendor # Invoice Date: |
| Invoice # Due Date: |
| Description:  |
| LINE ITEM | DEPT | ACCOUNT NAME | AMOUNT |
| 7415 |  | TRAVEL |  |
| Verified for Payment: Accounts Payable |
| Payment Approval: Exec. Dir. or CAO |