EDWIN FAIR COMMUNITY MENTAL HEALTH CENTER

***REQUEST FOR MEETING EXPENSE REIMBURSEMENT***

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

Name of Meeting or Training:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**IS THIS TRIP OUT OF OUR SERVICE AREA?**: YES NO (Circle One). If YES, submit original **“DETAILED”** meal tickets. If receipt does not show the business name please write it on the receipt.

TO RECEIVE A REIMBURSEMENT: ORIGINAL RECEIPTS must be attached to this form. Any request for reimbursement will be returned and will not be processed for payment until appropriate documentation is attached.

STATEMENT OF EXPENSES: (Enter $ amounts in spaces provided)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Date | Registration Fees(not pd in adv) | Lodging | Meals(out of catchment) | Air Fair /Auto Rental | Parking /Tolls | Total$$$ |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

 TOTAL (from above) $\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 TOTAL MILES\_\_\_\_\_\_\_‘X’ REIMBURSEMENT RATE \_\_\_\_\_\_ = $\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 TOTAL EXPENSES $\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 LESS ANY ADVANCE $\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 TOTAL AMOUNT OF REIMBURSEMENT $\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYEE AUTHORIZATION: I attest to the information submitted by me for reimbursement from Edwin Fair CMHC, Inc. for meeting expenses is true and correct.

Employee:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employee (Signature Required for Issuance of Check)

|  |
| --- |
|  Vendor # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Invoice Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Invoice # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Due Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Description |
| Line Item | Dept. | Account Name | Amount |
|  |  |  |  |
|  |  |  |  |
| Total |  |  |  |
| A/P checked | Admin Approval | Additional Approval |

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

 Coordinator or Management