

**McLaren Print System Order**

Order No: 50372  
 Order Date: 2019-11-19  
 User: colleen taraskavage  
 Phone: 810-658-6503

Ship Location: MMG Davison Community Medical Center  
 10090 E. Lippincott Blvd  
 Davison, Michigan 48423

**Forms**

Quantity: 100  
 Paragon Dept No: 50002  
 Dept Name: MMG Davison CMC  
 Company Number: 10

Order Total Price: 0.00

Item Number: M-150  
 Item Description: Request for Expense Reimbursement  
 Revision Date: 6/2012  
 Print: 2 sided black and white  
 Paper: 20# White Text  
 Size: 8.5 x 11  
 Fold:  
 Finish:  
 Drill: None  
 Misc Info:

REQUEST FOR EXPENSE REIMBURSEMENT MCLAREN HEALTH CARE

PURPOSE (Designate persons attending, name of meeting, location, inclusive dates, etc.)

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1. No 1 expense requires STATE tracking. 2. STATE tracking required, see attached. See policy on Expenses Contributed to Federal National Sources for additional information.

EXPENSES INCURRED (Attach original receipts/tickets)

**TRANSPORTATION:**

Air fare \$ \_\_\_\_\_  
 Personal auto miles at \$ \_\_\_\_\_ (State set standard rate) \_\_\_\_\_  
 Other (Expans) \_\_\_\_\_ \$ \_\_\_\_\_

**LODGING:**

Rate of \$ \_\_\_\_\_ \$ \_\_\_\_\_  
 Other \_\_\_\_\_ \$ \_\_\_\_\_

MEALS	DATE	BREAKFAST	LUNCH	DINNER	TOTAL
		\$ _____	\$ _____	\$ _____	\$ _____
		\$ _____	\$ _____	\$ _____	\$ _____
		\$ _____	\$ _____	\$ _____	\$ _____
		\$ _____	\$ _____	\$ _____	\$ _____
		\$ _____	\$ _____	\$ _____	\$ _____
		\$ _____	\$ _____	\$ _____	\$ _____
		\$ _____	\$ _____	\$ _____	\$ _____
		\$ _____	\$ _____	\$ _____	\$ _____
		\$ _____	\$ _____	\$ _____	\$ _____
		\$ _____	\$ _____	\$ _____	\$ _____

**OTHER EXPENSES (include registration fees, tips, cab fares, etc.)**

DATE	EXPLANATION	AMOUNT
		\$ _____
		\$ _____
		\$ _____
		\$ _____
		\$ _____
		\$ _____
		\$ _____
		\$ _____
		\$ _____
		\$ _____

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

**DEBIT AMOUNTS PAID BY MCLAREN HEALTH CARE:**

Transportation \$ \_\_\_\_\_  
 Lodging \$ \_\_\_\_\_  
 Cash advanced for expenses \$ \_\_\_\_\_  
 Other (Expans) \$ \_\_\_\_\_

**DIFFERENCE:**

Amount for employee \$ \_\_\_\_\_  
 Employee Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Amount for McLaren Health Care \$ \_\_\_\_\_

**Signature**

Account No. \_\_\_\_\_  
 Account No. \_\_\_\_\_  
 00000000

**Spec Info:**