

McLaren Print System Order

Order No: 7142
 Order Date: 2014-11-14
 User: Denise Turner
 Phone: 810 342-1711

Ship Location: Denise Turner
 1314 S. Linden Rd., Suite C
 Flint, MI 48532

Forms
 Quantity: 100
 Paragon Dept No: 63550
 Dept Name: McLaren-Flint Community Medical Center
 Company Number: 810

Order Total Price: 0.00

Item Number: M-150
 Item Description: Request for Expense Reimbursement
 Revision Date: 6/2013
 Print: 2 sided black and white
 Paper: 20# White Text
 Size: 8.5 x 11
 Fold:
 Finish:
 Drill:
 Misc Info:

REQUEST FOR EXPENSE REIMBURSEMENT MCLAREN HEALTH CARE

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

1. Non-STATE 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 individual rates)
 Other (Expans) _____ \$ _____

LODGING:

Other _____ \$ _____
 Other _____ \$ _____

MEALS:

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

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

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

TOTAL EXPENSES \$ _____

Submitted by: _____ Title: _____
 Approved: _____ Title: _____
 Date: _____

DEBIT AMOUNTS PAID BY MCLAREN HEALTH CARE:

Transportation \$ _____
 Lodging \$ _____
 Meals advanced for expense \$ _____
 Other (Expans) \$ _____

DIFFERENCE:

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

Amount \$ _____
 Account No. \$ _____
 Account No. \$ _____