

McLaren Print System Order

Order No: 7921 Reprint Previous Order No: 7919
Order Date: 2015-01-02
User: Dawn Conlen
Phone: 810-342-2063

Ship Location: 4 North room 405 attention Dawn Conlen
401 S Ballenger Hwy
Flint, MI 48532

Forms

Quantity: 100
Paragon Dept No: 94032
Dept Name: Internal Medicine Residency Program
Company Number: 60

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.)

1. Non-USA expenses require US/ATAF tracking. 2. US/ATAF tracking required, see attached.
See policy on Expenses Contributed to Federal National Sources for additional information.
EXPENSES INCURRED (Attach original receipts/coupons)

TRANSPORTATION:

Air fare \$ _____
Personal auto _____ Miles at \$ _____ (State all individual fares) _____
Other (Expans) _____ \$ _____

LODGING:

Other _____ \$ _____
Other _____ \$ _____

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

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

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

TOTAL EXPENSES \$ _____

Submitted by: _____ Title: _____
Approved: _____ Title: _____
Supervisor/Doctor: _____ Title: _____
See Treasurer: _____ Title: _____

DEBIT AMOUNTS PAID BY MCLAREN HEALTH CARE:

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

DIFFERENCE:

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

Amount \$ _____
Amount \$ _____
Amount \$ _____