

McLaren Print System Order

Order No: 8203 Reprint Previous Order No: 7919  
Order Date: 2015-01-14  
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-Union 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/coupons)

**TRANSPORTATION:**

Air fare \$ \_\_\_\_\_  
Personal auto \_\_\_\_\_ (Mileage included here)  
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: _____	<b>DEBIT ACCOUNTS PAID BY MCLAREN HEALTH CARE:</b>	
Approved: _____	Transportation \$ _____	
Supervisor/Doctor: _____	Travel advanced for expenses _____	
See Treasurer: _____	Other (Expans) _____	\$ _____
	<b>DIFFERENCE:</b>	
	Amount for employee _____	\$ _____
	Employee Name _____	
	Address _____	
	Amount for McLaren Health Care _____	\$ _____
	<b>Balance</b>	

Account No: \_\_\_\_\_  
Account No: \_\_\_\_\_  
\*\*\*\*\*