

McLaren Print System Order

Order No: 6515
 Order Date: 2014-10-16
 User: Angela DeLaRosa
 Phone: 3720 Katalin Ct, Suite 201 (989) 893-9705

Ship Location: McLaren Bay Region Family Medicine/Attn Angela DeLaRosa
 3720 Katalin Ct
 Bay City, MI 48706

Forms
 Quantity: 100
 Paragon Dept No: 69000
 Dept Name: McLaren Medical Group
 Company Number: 810

Order Total Price: 0.00

Item Number: M-150
 Item Description: Request for Expense Reimbursement
 Revision Date:
 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. 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 or national fare) _____
 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 \$ _____

Submitted by: _____
 Approved: _____
 Date: _____

DEBIT ACCOUNTS 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 _____

Amount \$ _____

Account No: _____
 Account No: _____
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