

McLaren Print System Order

Order No: 7436
 Order Date: 2014-12-02
 User: Erica Kamyszek
 Phone: 9897342171

Ship Location: Rogers City Medical Group
 573 N Bradley Hwy
 Rogers City, MICHIGAN 49779

Forms

Quantity: 100
 Paragon Dept No: 77025
 Dept Name: Rogers City Medical Group
 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-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 \$ _____) (Mileage allowance rate) _____
 Other (Expenses) _____ \$ _____

LODGING:

Other (Rate at \$ _____) _____ \$ _____
 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: _____
 Date: _____

DEBIT AMOUNTS PAID BY MCLAREN HEALTH CARE:

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

DIFFERENCE:

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

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