

McLaren Print System Order

Order No: 8341  
Order Date: 2015-01-21  
User: Sandra Garcia  
Phone: 989.922.4900

Ship Location: McLaren Bay Psychiatric Associates  
690 S. Trumbull St  
Bay City, MI 48708

Forms

Quantity: 100  
Paragon Dept No: 60735  
Dept Name: McLaren Bay Psychiatric Associates  
Company Number: 210

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.)

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1. Non-USA expenses require US/ATAR tracking. 2. US/ATAR 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 \$ \_\_\_\_\_ (Rate at individual fare) \_\_\_\_\_  
Other (Expans): \_\_\_\_\_ \$ \_\_\_\_\_

**LODGING:**

Other: \_\_\_\_\_ \$ \_\_\_\_\_  
Other: \_\_\_\_\_ \$ \_\_\_\_\_

| MEALS: | DATE | BREAKFAST | LUNCH | DINNER | TOTAL |
|--------|------|-----------|-------|--------|-------|
|        |      | \$        | \$    | \$     | \$    |
|        |      |           |       |        |       |
|        |      |           |       |        |       |
|        |      |           |       |        |       |
|        |      |           |       |        | \$    |

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

| DATE | EXPLANATION | AMOUNT |
|------|-------------|--------|
|      |             | \$     |
|      |             |        |
|      |             |        |
|      |             | \$     |

**TOTAL EXPENSES** \$ \_\_\_\_\_

Submitted by: \_\_\_\_\_  
Approved: \_\_\_\_\_  
Supervisor/Doctor: \_\_\_\_\_  
See Treasurer: \_\_\_\_\_

**DEBIT AMOUNTS PAID BY MCLAREN HEALTH CARE:**

Transportation: \_\_\_\_\_  
Lodging: \_\_\_\_\_  
Meal advanced for expense: \_\_\_\_\_  
Other (Expans): \_\_\_\_\_

**DIFFERENCE:**

Amount for employee: \_\_\_\_\_  
Employee Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Amount for McLaren Health Care: \_\_\_\_\_

Amount: \_\_\_\_\_

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