

McLaren Print System Order

Order No: 8577
 Order Date: 2015-01-28
 User: Wanda Graves
 Phone: (810) 342-2177

Ship Location: Nursing Office
 401 S. Ballenger HWY.
 Flint, Michigan 48532

Forms
 Quantity: 100
 Paragon Dept No: 91020
 Dept Name: Nursing Office
 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. 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 set individual rates) _____
 Other (Expenses) _____ \$ _____

LODGING:

Other _____ \$ _____
 Other _____ \$ _____

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

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

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

TOTAL EXPENSES \$ _____

Submitted by: _____ Title: _____
 Approved: _____ Title: _____
 Date: _____

DEBIT ACCOUNTS 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: _____
 Account No: _____