St. Peter's Health

Expense Report

Instructions: Please provide the following expense information below for reimbursement that has not been previously paid for by the hospital or the hospital credit card. You will be required to submit original receipts for expenses being claimed.

Employee Name - please fill in your first and last name.

Address to be Mailed - if you would like your check to be mailed, please include the address in which you wish to receive it.

Department - please provide the department number the expense was previously approved to be charged.

Purpose of Travel - please provide the reason for travel or conference name.

Vendor - please provide the name of vendor the expense (i.e. Delta, Hilton, etc.)

Item / Attendees - please provide the item and/or names of individuals attending in which you are seeking reimbursement.

Dates of Travel - please list expenses by date within each category. Meals should be a totaled by day in which the expense was incurred.

Attach a copy of the approved travel requests as part of the expense report.

Employee Name: _____ Department: _____

Address to be Mailed: _____

_____

Purpose of Travel: _____

		Dates of Travel							
Vendor	**Item / Attendees**							/ /	**Total**
Mileage (Private Car)									
Miles x cents per mile									
Total									

Balance Due to Employee	

By signing below, I certify the claim for reimbursement include expenses incurred by me for the said travel outlined above, expenses incurred and claimed were only those expenses necessary during this travel, and the attached original receipts are a true and correct reflection of expenses incurred by me.

Employee Signature Date

Director or VP Approval Date

**Unless charged to 9100, then Ed. Dept. approves*

Updated: 10/10/2013