Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: ­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Purpose of trip: \_\_\_\_\_\_

To and From: \_\_\_\_\_\_\_\_\_\_

**TRAVEL EXPENSES** (Attach Receipts)

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Mon | Tues | Wed | Thurs | Fri | Sat | Sun | Total |
| Date |  |  |  |  |  |  |  |  |
| Miles Driven  Mileage @ .56/mile\* |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| Taxi, Tolls & Transportation\*\* |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| Hotel |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| Meals (Max per day $50) And can eat any meals provided at the conference. |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| Air Travel\*\* |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **Totals** |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  | | | | TOTAL REIMBURSABLE EXPENSE | | | | $ |

***\*IRS Mileage Rate Allowed***

***\*\*Please use economy airfare.***

***I certify that I am familiar with the provisions of the WAMSS Expense Statement and Travel Policy and this Expense Reimbursement Report is accurate as to actual and necessary business expense.***

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you should have any question, please feel free to contact Heidi Martinez.

Thank you,

**Molly Nagel, CPMSM**

**State Treasurer**

**Michele Sabol, CPCS**

**Past-President / Conference Planning Chair**

**Submit with receipts by email to:**

WAMSS Treasurer:

C/O Molly Nagel,

2127 Fireside Lane

Oak Harbor, WA 98277

[wamsstreasurer@gmail.com](mailto:gisela.mejia@harrisonmedical.org)

WAMSS Conference Planning Chair:

Michele Sabol, CPCS

[michele.sabol@healthspring.com](mailto:michele.sabol@healthspring.com)

|  |
| --- |
| **FOR OFFICE USE ONLY**  Check # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Paid : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Account(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |