Jersey Community Hospital
Expense Reimbursement

NAME: _____ **DATE**

PURPOSE OF TRIP: _____

			AUTO MILEAGE		MILES	AMOUNT
DATE	DEPART (PLACE)	ARRIVE (PLACE)	START	END	TRAVELED	
						$0.00
						$0.00
						$0.00
						$0.00
						$0.00

Vouchers must be submitted for all items below:

DATE	PURPOSE	PAID TO	PREPAID	AMOUNT
	EDUCATION			
	LODGING			
	MEALS			
	TRAVEL EXPENSE			
	PARKING & TOLLS			
	OTHER			

TOTAL EXPENSE OF TRIP _____

PREPAID AMOUNT _____

AMOUNT DUE EMPLOYEE _____

_____
EMPLOYEE'S SIGNATURE:

_____
APPROVED BY:

_____
ADMINISTRATOR

THIS VOUCHER MUST ACCOMPANY ALL REQUESTS FOR CHECKS