Missouri State Medical Association Alliance

Reimbursement/Expenses Voucher Form

Date of Request_____ Name of Person submitting request_____
To whom check is to be written_____
Mailing Address_____City_____State_____
Zip_____ H or W Phone (___)_____ Fax (___)_____ E-mail_____
Amount of Reimbursement/bill payment requested _____

DESCRIPTIONS	AMOUNT	EVENT	Office/Committee & Budget Category
I. Desk Expenses Total			
A. Phone			
B. Postage			
C. Photocopying/ Printing			
D. Other (attach Itemized list)			
II. Travel Expense Total			
A. Meals			
B. Lodging			
C. Auto: Mileage ____@ $.565			
D. Air Fare			
E. Taxi			
F. Other (please Specify)			
III. Miscellaneous Total			
A. _____			
B. _____			
IV. Total Amount Column Here			

1. **ATTACH** to this form:
   a. **ALL RECEIPTS**
   b. Itemized lists and/ or explanations, if needed
2. **SUBMIT** this form for reimbursement to:

Finance & Budget Chair
Allene Wright
518 Pinewood Dr
St Joseph, MO 64506 allenew668@gmail.com

For Treasurer's use only (Initial here)_____

Date Paid _____ Check # _____
Voucher #_____

Amount of check _____
Account _____