

**SWEET MEDICAL CENTER, INC.
REQUEST FOR REIMBURSEMENT**

Name _____ Date _____

Reason for Reimbursement: _____

Dates Covered _____

Name and location of course/class/conference attended (if any) _____

Total Mileage _____
(Will be reimbursed at the current Federal rate of \$.50/mile)

OR

Cost of Transportation: _____
(Please attach receipt)

Lodging cost (be sure to attach receipt) _____
Reimbursement will only be made upon presentation of receipt.

If traveling, state date and time you left home _____

And date and time you arrived home _____

Meals purchased but not included in registration fees (Circle all that apply):
(Will be reimbursed at the rate of \$7 for breakfast, \$11 for lunch, \$18 for supper)

Day 1: Breakfast	Lunch	Supper
Day 2: Breakfast	Lunch	Supper
Day 3: Breakfast	Lunch	Supper
Day 4: Breakfast	Lunch	Supper
Day 5: Breakfast	Lunch	Supper

Registration fee _____

Was this registration fee paid by the Clinic in advance? Yes No

CEUs awarded for this class/course/conference _____

Have you furnished a copy of the CEUs for your personnel file? If not, please furnish a copy with this reimbursement request.

