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 allene@stjoelive.com

For Treasurer's use only (Initial here)___________

Date Paid ___________ Check # _________
Voucher #________

Amount of check ___________
Account ___________________