

Request for Expense Reimbursement

Directions:

- 1) All requests for reimbursement must be accompanied by **original** receipts, and **must be submitted within 60 days** of the approved event/activity.
- 2) Complete this form, make a copy for your records, attach original receipts, and mail to:
 Wisconsin Academy of Family Physicians, 10375 N Baldev Ct, Ste A, Mequon, WI 53092
(If there are no receipts required, you may email this form to academy@wafp.org.)
 Reimbursement checks will be processed and mailed within two weeks of submission.

Dates of Event _____

Name of Event _____

Location of Event _____

EXPENSES

Airfare \$ _____ attach receipts

Hotel \$ _____ attach receipts

Meals \$ _____ attach receipts

Travel expenses (parking, taxi, etc.) \$ _____ attach receipts

Mileage @ IRS approved amount _____ miles = \$ _____

Other (please describe) _____ \$ _____ attach receipts

_____ \$ _____ attach receipts

TOTAL EXPENSES \$ _____

I am donating all or a portion of my reimbursement to the WAFP-Foundation. DONATION AMOUNT \$ _____

TOTAL REIMBURSEMENT \$ _____

Requested by:

Name _____

Address _____

City, State, Zip _____

Signature _____ Date _____