WAFP WISCONSIN ACADEMY OF FAMILY PHYSICIANS

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, 210 Green Bay Road, Thiensville, 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 _____

09/2013