Pushmataha Hospital

Antlers, OK

Expense Report

(ATTACH ALL RECIEPTS TO BE REIMBURSED [Mileage Claims require Google/Mapquest Mapping printout of route to validate milleage claimed])

Name: _____   Address _____

Week Ending
Date: _____   Position/Dept _____

Date	Destination(s)	Other(s) Attending (Use if meal/expenses bought for others; use back for add'l space)	Travel Purpose (Use back for additional space)	Miles Traveled	Mileage Rate/mi	Mileage Amount	Meal(s) / Incidential(s) (up to $50/day/pers)	Other (Tolls, parking, airfare, taxi, etc)	Amount	Daily Total
					0.67	-				$ -
					0.67	-				$ -
					0.67	-				$ -
					0.67	-				$ -
					0.67	-				$ -
					0.67	-				$ -
					0.67	-				$ -
					0.67	-				$ -
					0.67	-				$ -
					0.67	-				$ -
					0.67	-				$ -
					0.67	-				$ -
Totals	XXXXX	XXXXX	XXXXX	-		-	0	XXXXX	0	$ -

I hereby certify that this is a true statement of miles driven and
travel expense for the month of _____, 20_____

Signed: _____

Approved: _____

*Note: all trips over 500 miles one way or $2,000 needs to have Board Member approval:_____

Less: Advance Issued   _____

Less: Hospital Paid   _____

Reimbursement / (Refund) due: $_____ -

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