Expense Reimbursement Form

Promise Community Health Center

Updated 1/06/2025

NAME _____

Date of Expense	Vendor/Description/Patient #	Start AND end location	Purpose of Trip/Purchase	Grant?	Mileage	Subtotal
				Y/N	X 0.70	
				Y/N	X 0.70	
				Y/N	X 0.70	
				Y/N	X 0.70	
				Y/N	X 0.70	
				Y/N	X 0.70	
				Y/N	X 0.70	
				Y/N	X 0.70	
				Y/N	X 0.70	
				Y/N	X 0.70	
				Y/N	X 0.70	
				Y/N	X 0.70	
				Y/N	X 0.70	
				Y/N	X 0.70	
				Y/N	X 0.70	
				Y/N	X 0.70	
				Y/N	X 0.70	
					TOTAL EXPENSES	

Attach receipts for all expenses

See Employee Handbook for allowable expenses

_____

Date Submitted

_____

Signature

_____

Supervisor Signature

(Please place signed form in invoice inbox by Rebecca)