PUSHMATAHA HOSPITAL

Antlers, OK

Expense Report

(ATTACH ALL RECIEPTS TO BE REIMBURSED [excl Mileage Claims require Mapping printout])

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
					0.56	-				$ -
					0.56	-				$ -
					0.56	-				$ -
					0.56	-				$ -
					0.56	-				$ -
					0.56	-				$ -
					0.56	-				$ -
					0.56	-				$ -
					0.56	-				$ -
					0.56	-				$ -
					0.56	-				$ -
					0.56	-				$ -
Totals	XXXXX	XXXXX	XXXXX	-		-		XXXXX		$ -

Less: Advance Issued _____

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

Less: Hospital Paid _____

Reimbursement / (Refund) due: $ -

Signed: _____

Approved: _____

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

Rev 01/2021