Methodist Health System Foundation, Inc.

TRAVEL EXPENSE FORM

NAME:______________________________ DATE:______________________

DEPARTMENT:______________________________ DEPT/COST CENTER #:______________________

PURPOSE:______________________________ DESTINATION:______________________

		SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	TOTAL
	DATE ((MM/DD/YY)								
	TRANSPORTATION								
MEALS	BREAKFAST								
	LUNCH								
	DINNER								
	LODGING								
	AUTO RENTAL								
	PARKING								
	PHONE & FAX								
	TAXI/BUS/TOLLS								
	TIPS								
	OTHER (LIST)								
	SUBTOTAL EXPENSES	$	$	$	$	$	$	$	$
MILEAGE	BEGINNING ODOMETER READING								
	ENDING ODOMETER READING								
	TOTAL MILES FOR DAY								

MILEAGE EXPENSE TOTAL MILES FOR WEEK _________ @ $0.54¢ MILE =	$
TOTAL (SUBTOTAL + MILEAGE) **EXPENSES**	$
LESS ADVANCED RECEIVED	$
ADDITIONAL AMOUNT DUE/PAYABLE	$

TRAVEL TIME								
	BEGAN							
	ENDED							

CERTIFICATION STATEMENT:

"I hereby certify that the above listed expenses were incurred for the benefit of Methodist Health System Foundation, Inc. and I agree to reimburse Methodist Health System Foundation, Inc. in full for any and all items subsequently found to be listed in error."

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Signature Date

______________________________ ______________________________

Department Director/Vice President Executive Vice President/President (If applicable)

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