



HEALTH RESEARCH ASSOCIATION

Los Angeles County / University of Southern California Medical Center

REQUEST # T 10955

TRAVEL EXPENSE REIMBURSEMENT REQUEST

NAME: _____ DATE OF REQUEST: _____

MAILING ADDRESS: _____ TRAVEL DATES _____

START: _____

END: _____

DESTINATION: _____

TRAVEL PURPOSE: _____

All expenses listed must have an ORIGINAL receipt for documentation. Affix all receipts to letter size paper and attach to this cover page.

TRANSPORTATION (Air/Auto/Taxis)

TYPE	COMPANY	DATE	AMOUNT

HOTEL (Room Charge and Tax Only)

NAME	DATES OF STAY	DAILY RATE	AMOUNT

MEALS *

DATE	BREAKFAST	LUNCH	DINNER	OTHER	TOTAL

*For each meal above which included guests, list names and project relationship:

INCIDENTAL EXPENSES (Tips, Registration, Phone Charges, Etc.)

DATE	EXPENSE DESCRIPTION	AMOUNT

AUTHORIZED PROJECT SIGNATURE: _____

TOTAL EXPENSE:	\$
Less Advance:	\$
AMOUNT DUE:	\$

PROJECT # _____ G/L# _____

VENDOR #	_____
COMMITMENT #	_____
B/C BY:	_____
B/C DATE:	_____

CONTACT/PHONE: _____

CHECK DISPOSITION: MAIL _____ HOLD _____

WHITE COPY-BUSINESS OFFICE, YELLOW COPY-ORIGINATOR.
SEND ORIGINAL RECEIPTS TO THE BUSINESS OFFICE.