

~ NEW YORK STATE ASSOCIATION for MEDICAL STAFF SERVICES ~

EXPENSE REPORT

Name _____ NYSAMSS Position _____

Address _____

Phone: (Home) _____ (Work) _____

TRAVEL EXPENSES

Purpose of Trip _____

Dates _____ Destination _____

DATES					
Airfare					
Public Transportation					
Mileage (\$.535/mile - as of 1/1/17)					
Parking					
Tolls					
Hotel					
TOTAL EXPENSES/DAY					

ADMINISTRATIVE EXPENSES

DESCRIPTION	AMOUNT
Printing/Copying:	\$
Postage:	\$
Office Supplies:	\$
Other:	\$
TOTAL EXPENSES:	\$

TOTAL REIMBURSEMENT: \$ _____ For Office Use Only: Check # _____ Date Paid _____