

~ NEW YORK STATE ASSOCIATION for MEDICAL STAFF SERVICES ~

SPEAKER EXPENSE REPORT

Speaker Name _____

Address _____

Phone: (Home) _____ (Work) _____

TRAVEL EXPENSES

Purpose of Trip _____

Dates _____ Destination _____

DATES					
Airfare					
Public Transportation					
Mileage (\$.545/mile - as of 1/1/18)					
Parking					
Tolls					
Hotel					
Meals: Breakfast					
Lunch					
Dinner					
TOTAL EXPENSES/DAY					

ADMINISTRATIVE EXPENSES

DESCRIPTION	AMOUNT
Honorarium:	\$
Other:	\$
TOTAL ADMINISTRATIVE EXPENSES:	\$

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

Unless otherwise previously agreed to, all expenses must be submitted to NYSAMSS within sixty days of the speaking engagement.