~ 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 ($.545/mile - as of 1/1/18)					
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 _____