# UNIVERSITY OF SOUTH ALABAMA
## HEALTH SERVICES FOUNDATION
## REIMBURSEMENT REQUEST

Name _____ Title _____ Date _____

Office Address _____ Dept/Division _____ Acct: _____

Business Reason _____ $/Mile _____ Acct: _____

| Dates | Hour of Depart/Ret AM | PM | Points of Travel From | To | Transportation Mode | Mileage | Amount | Meals B'fast | Lunch | Dinner | Daily Amount | Lodging Daily Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | 0.00 | | | | 0.00 | |
| | | | | | | | 0.00 | | | | 0.00 | |
| | | | | | | | 0.00 | | | | 0.00 | |
| | | | | | | | 0.00 | | | | 0.00 | |
| | | | | | | | 0.00 | | | | 0.00 | |
| | | | | | | | 0.00 | | | | 0.00 | |
| | | | | | | | 0.00 | | | | 0.00 | |
| | | | | | | | 0.00 | | | | 0.00 | |
| | | | | | Transportation | | | | | | Meals | Lodging |
| | | | | Page 1 Totals | $ 0.00 | | | | | | $ 0.00 | $ 0.00 |
| | | | | | Transportation | | | | | | Meals | Lodging |
| | | | | Page 2 Totals | $ | | | | | | $ | $ |
| | | | | | | | | | | First + Second Page Total | | $ 0.00 |

| | | |
|---|---|---|
| **Other Expenses** (Itemize other expense included above Such as airline tickets, ect., and attach second sheet if necessary ) | | $ |
| | | $ |
| | | $ |
| | | $ |
| | **Other Expense Total** | $ 0.00 |
| | **Page 2 Other Expense Total** | $ |
| (Transportation + Meals + Lodging + Other Expenses) | **Travel Expense Total** | $ 0.00 |
| **Prepaid Expenses** ( **NEGATIVES ONLY** ) ( Itemize prepaid expenses included above. Such as airline tickets, ect., and attach second sheet if necessary ) | | $ |
| | | $ |
| | | $ |
| | | $ |
| | **Prepaid Expense Total** | $ 0.00 |
| | **Page 2 Prepaid Expense Total** | $ |
| | **Grand Total** | $ 0.00 |

**CERTIFICATION**

I hereby certify that the expenses incurred in the preformance of official duties pursuant to authority granted to me.

Payee Signature

Date

☐ Payee _____
☐ Department c/o _____
☐ Location _____

**APPROVAL FOR PAYMENT**

Department Head/Chairperson

College of Medicine Business Office

Health Services Foundation Administration

Health Services Foundation Administration

Date Paid _____

Check No._____

Revised December 22, 2008