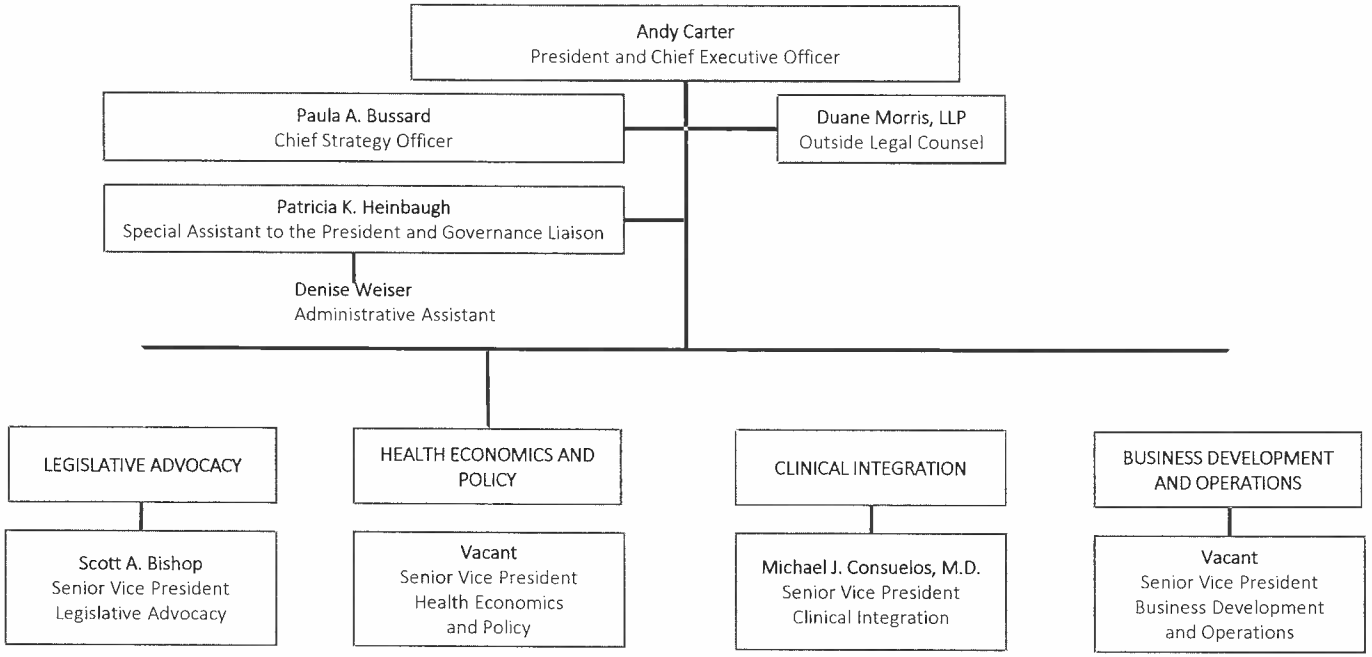
The Hospital & Healthsystem Association of Pennsylvania



Revised 4-21-15

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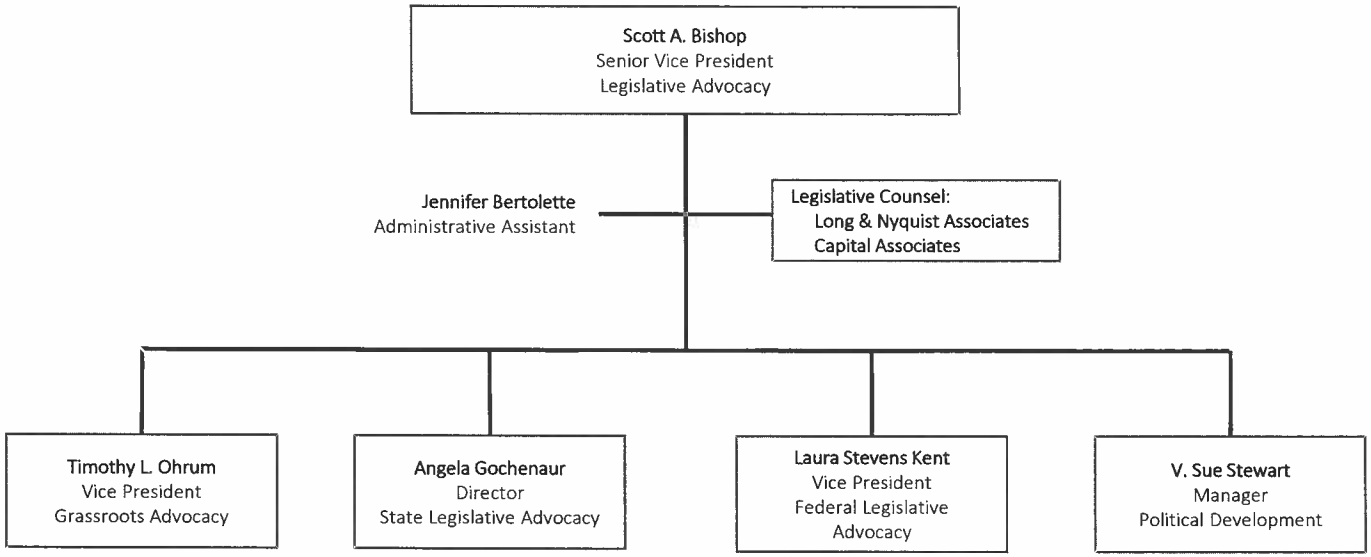
LEGISLATIVE ADVOCACY



Revised 4-21-15

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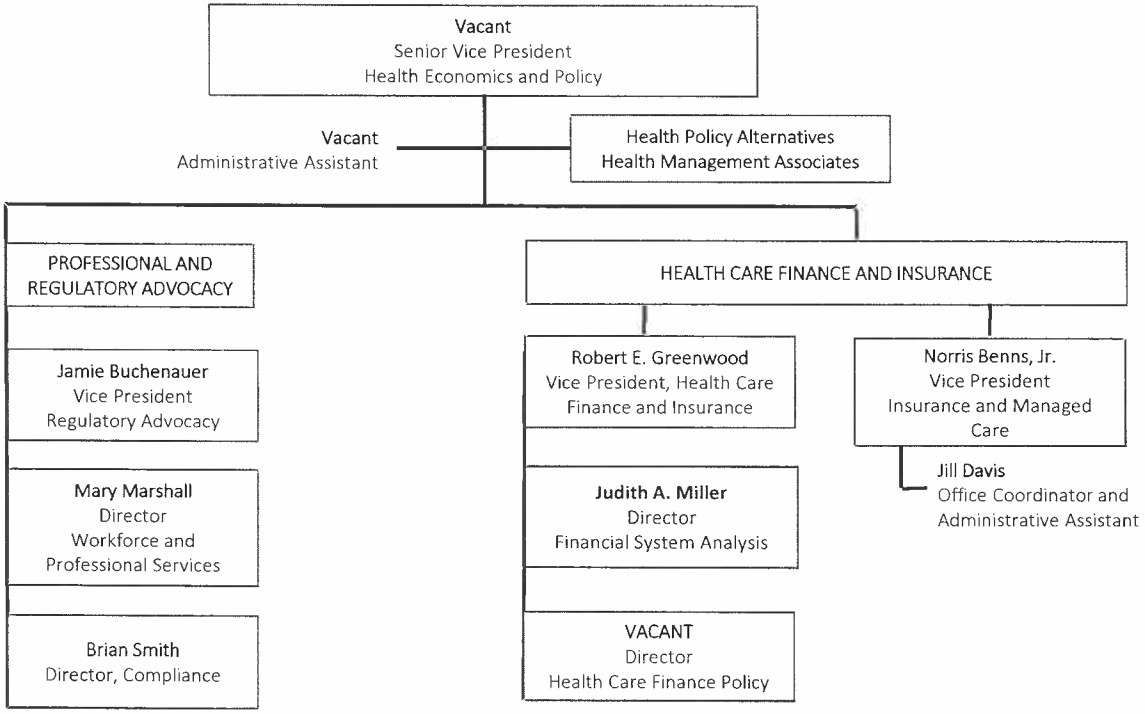
HEALTH ECONOMICS AND POLICY



Revised 4-21-15

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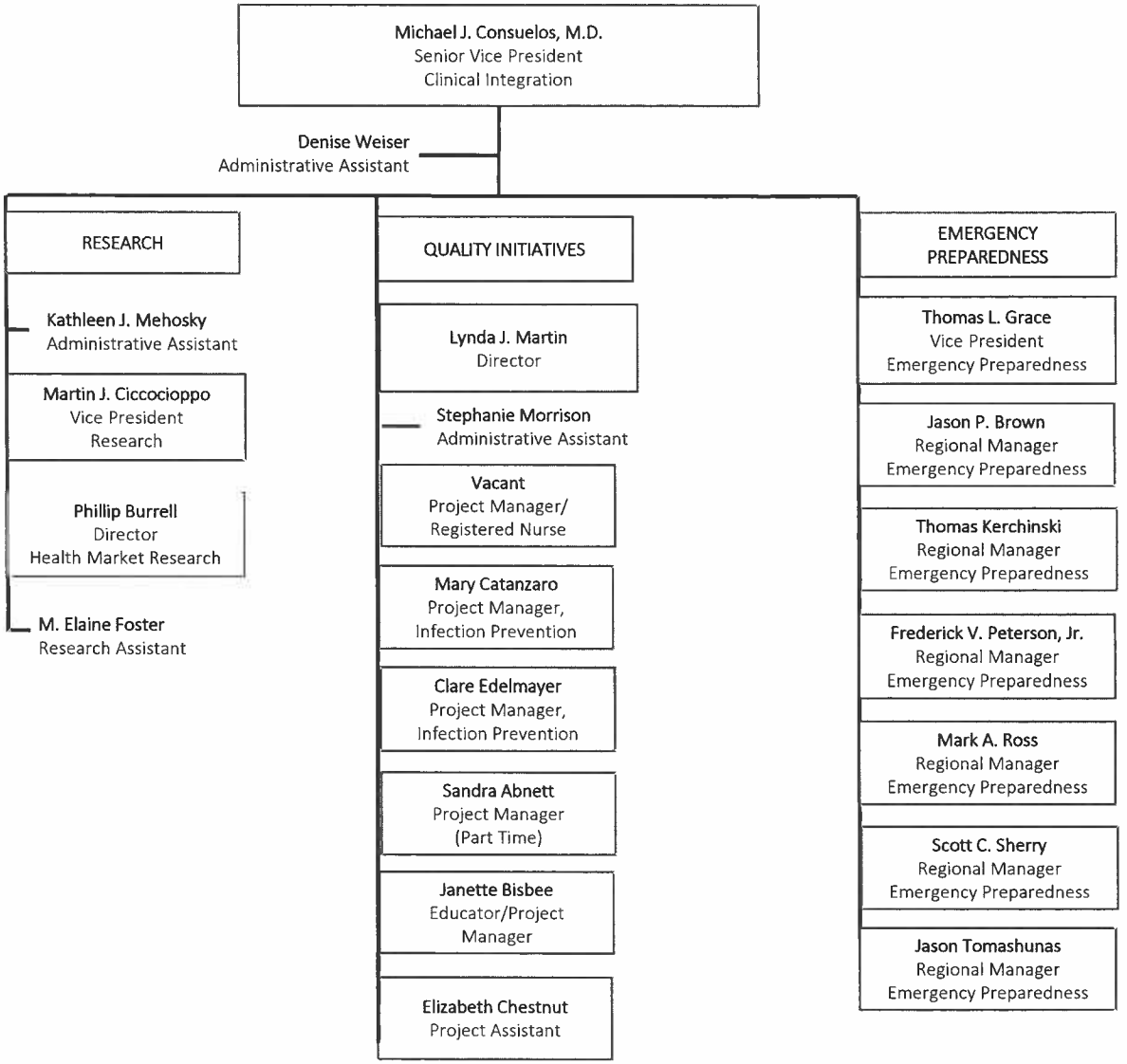
CLINICAL INTEGRATION



Revised 4-21-15

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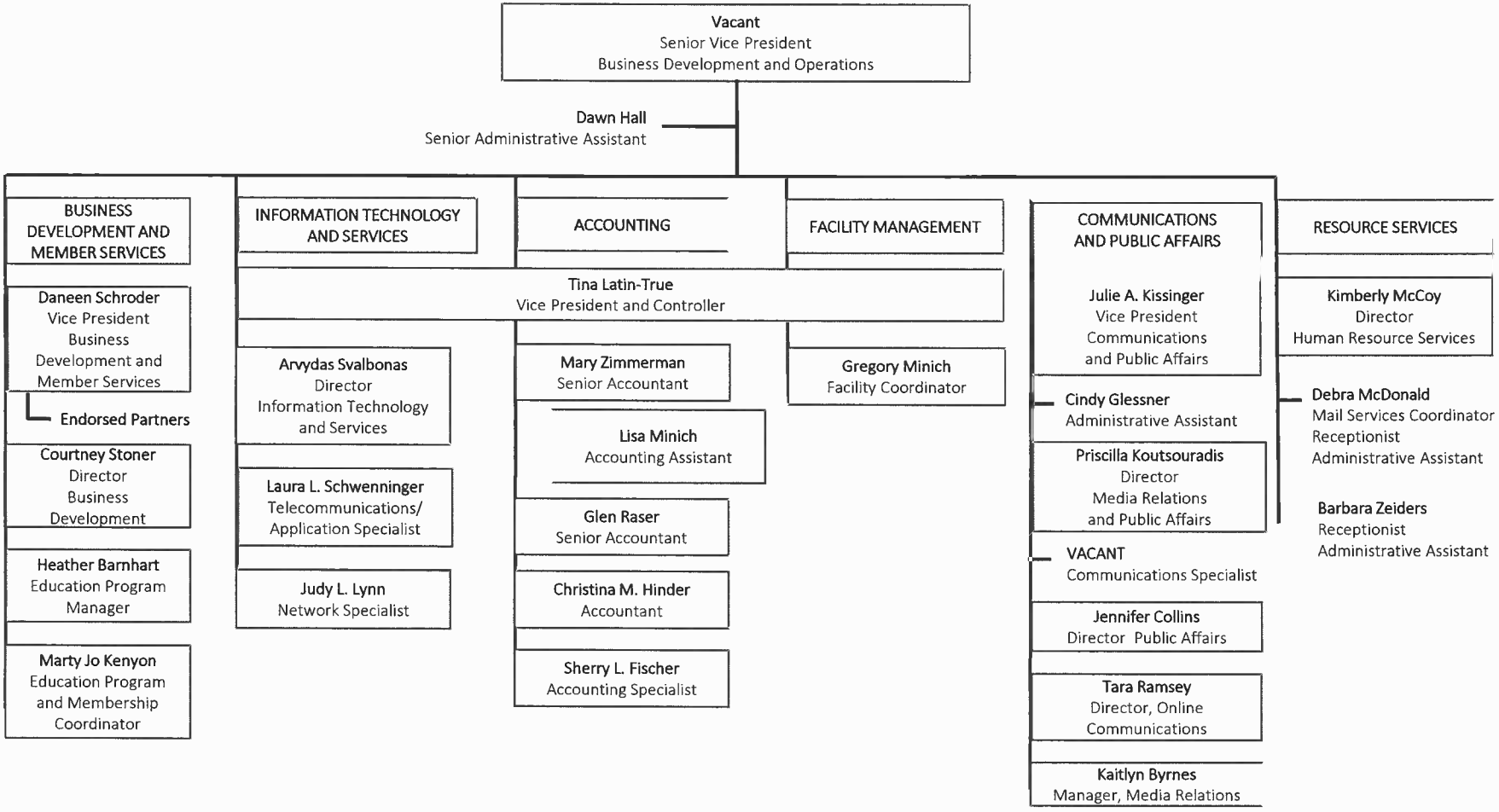
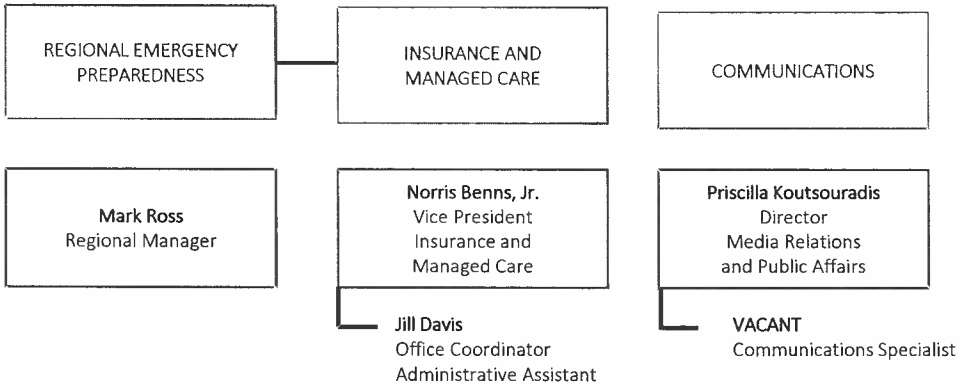
BUSINESS DEVELOPMENT AND OPERATIONS



Revised 4-21-15

The Hospital & Healthsystem Association of Pennsylvania
DELAWARE VALLEY HEALTHCARE COUNCIL OF HAP



Revised 4-21-15

Return to: _____

2015

NON-STAFF BUSINESS & TRAVEL EXPENSE FORM

Request for Reimbursement

The Hospital & Healthsystem Association of Pennsylvania, PO Box 8600 Harrisburg, PA 17105-8600

Name & Title:	
Organization:	
Meeting/Function:	
Location:	
Date(s):	

Please see the 2nd page of this form for an explanation of allowable expenses. **Original receipts must be attached for all expenses.**

Transportation From:	**To & Return:**	
Total Miles:	**2015 rate $.575/mile =**	
Tolls:		
Airline:		
Rental Car:		
Taxi:		
Hotel:		
Breakfast:		
Lunch:		
Dinner:		
Other Expenses:		
	Total Reimbursement Requested	

Make Reimbursement Payable To: _____

At the Following Address: _____

_____

_____

The following expenses were incurred by me in pursuit of HAP corporate business. I have not been, nor will I be reimbursed by any other source. My personal expenses have been excluded.

Signature x _____

Title _____ **Date** _____

OFFICE USE ONLY	
Approved By:	
Title:	
Date:	
Account #:	

FOR ACCOUNTING USE ONLY	
Date Rec'd	
Extensions Ck'd	
Date Paid	
Check #	