

NORTH DAKOTA ACADEMY OF PHYSICIAN ASSISTANTS
REIMBURSEMENT OF EXPENSES FORM

Name _____
 Address _____
 City _____ State _____ Zip _____
 Purpose _____
 Authorized By _____ Date _____

DAY	Mon	Tues	Wed	Thur	Fri	Sat	Sun	Total Expense \$
DATE								
Transportation (Part A on Back)								
Breakfast (\$4.00)								
Lunch (\$6.00)								
Dinner (\$10.00)								
Lodging								
Telephone (Part B on Back)								
Postage (Part C on Back)								
Supplies (Part D on Back)								
\$25.00 Meeting Reimbursement								
Miscellaneous (Part E on Back)								
Total Expenses								

Please submit to:
Pat Bloomquist
8268 Hwy 40
Battleview, ND 58773

e-mail: patrnpac@yahoo.com

I certify this statement accurate as to actual and necessary business expenses:

 (Signature)

A. Transportation:

Date	Points Covered by Travel (Include Departure and Return Times)	Miles	(Put total on Front) \$.31/mile
Ex. 5/1/00	Minot – Bismarck-Minot 8 am – 5 p.m.	225	\$69.75

B. Telephone: Explain purpose of calls (e.g. CME business, legislative committee business, etc. and attach copy of phone bill). List total on front.

	\$
	\$
	\$

C. Postage: Specify date and purpose (e.g. mailed CME topics survey to all members; mailed report to Board members, etc. and attach receipts) List total on front.

	\$
	\$
	\$

D. Supplies: specify item and purpose (e.g. envelopes to mail survey to academy members, etc. and attach receipts.) List total on front.

	\$
	\$
	\$

E. Miscellaneous: List miscellaneous expenses (e.g. parking fees, copying services, etc.) List total on front.

	\$
	\$
	\$