



## Request for Expense Reimbursement

**Directions:**

- 1) All requests for reimbursement must be accompanied by **original** receipts, and **must be submitted within 60 days** of the approved event/activity.
- 2) Complete this form, make a copy for your records, attach **original** receipts, and mail to:  
Maryland Academy of Family Physicians, 210 Green Bay Road, Thiensville, WI 53092.  
*(If there are no receipts required, you may fax this form to 262-242-1862.)*  
Reimbursement checks will be processed and mailed within two weeks of submission.

Dates of Event \_\_\_\_\_

Name of Event \_\_\_\_\_

Location of Event \_\_\_\_\_

**EXPENSES**

Airfare	\$ _____	attach receipts
Hotel	\$ _____	attach receipts
Meals	\$ _____	attach receipts
Travel expenses (parking, taxi, etc.)	\$ _____	attach receipts
Mileage @ IRS approved amount ___ miles =	\$ _____	
Other (please describe) _____	\$ _____	attach receipts
_____	\$ _____	attach receipts

**TOTAL EXPENSES** \$ \_\_\_\_\_

**I am donating all or a portion of my reimbursement to the MDAFP-Foundation. DONATION AMOUNT** \$ \_\_\_\_\_

**TOTAL REIMBURSEMENT** \$ \_\_\_\_\_

**Requested by:**

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_