Santa Barbara Dental Hygienists' Association
REIMBURSEMENT VOUCHER

COMMTTEE NAME ____

PURPOSE____

NAME ____ PHONE____________

ADDRESS ____

CITY________________________ STATE______________ZIP_________

EXPENSE ITEMS FOR REIMBURSEMENT AMOUNT

Date(s) __________

Air Fare __________

Hotel __________

Per Diem ___days @ _____ */day* __________

Auto @/_____/mi __________

Parking __________

Tolls __________

COMMITTEE/PROGRAM

Date(s) __________

Postage __________

Telephone __________

Print/Copy __________

Supplies __________

Other ______________________ __________

______________________ __________

______________________ __________

TOTAL __________

(Paid receipts MUST be attached)

Signature ____

FOR OFFICE USE ONLY

DATE PAID _____CHECK # _________

APPROVED BY: ____