SOUTHERN REGION EMERGENCY MEDICAL SERVICES, INC

TRAVEL EXPENSE REPORT FOR CERTIFYING OFFICERS

NAME: _____ **Mailing Address:** _____

Title: _____ _____

Departure (street address): _____ **Departure date/time:** _____

Destination (street address): _____ **Return date/time:** _____

Location and Purpose of travel: _____

PLEASE COMPLETE ALL INFORMATION, ATTACH RECEIPTS and send to SREMSC, 6130 Tuttle Place, Suite B, Anchorage, AK 99507.
This from must be returned to SREMSC within 5 business days after travel completion.

MEALS

DATE	B	L	D	Personally Paid	Paid by SREMSC
Sub-total:					

DATE	B	L	D	Personally Paid	Paid by SREMSC
Sub-total:					

LODGING

DATE	DESCRIPTION	Personally Paid	Paid by SREMSC
Sub-total:			

TRANSPORTATION / OTHER

DATE	DESCRIPTION	Personally Paid	Paid by SREMSC
	Mileage (X .58 (IRS-2019))		
Sub-total:			

TOTAL:		

I certify this report to be true and correct.

Signature _____ Date _____ Approved _____ Date _____

Approved _____ Date _____

ACCOUNTING USE ONLY			
Account		Amount	$
Account		Amount	$
Account		Amount	$
Invoice Date:		Invoice #:	
Check Date:		Check #:	