SOUTHERN REGION EMERGENCY MEDICAL SERVICES, INC

TRAVEL EXPENSE REPORT

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 form must be submitted to SREMSC within 5 business days after travel completion.

MEALS

DATE	Breakfast 12 am-10am	Lunch 10 am-3pm	Dinner 3 pm-12am	Personally Paid	Paid by SREMSC
Sub-total:					

DATE	Breakfast 12 am-10am	Lunch 10 am-3pm	Dinner 3 pm-12am	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 #:	