NORTHWEST Kidney Centers

Expense Report

Employee:					Department:			
REIMBURSABLE CASH EXPENDITURES (Attach Receipts)								
Date	**Location**	**Description**	**# of Miles***	**Mileage Value**	**Lodging**	**Personal Meals**	**Other**	
								Total Across
		TOTALS		$	$	$	$	$
Make Check Payable to:						Account Codes		Amount
Mail Check to:				Distribute Cash Expenditures To:				
Requested by: (signature)								
						Subtotal		
Approved by: (signature)						(Less Advance)		
						DUE EMPLOYEE		

Reimbursement time limits: local travel within 12 weeks of return and within 30 days of fiscal year end, beyond local travel within four weeks of return of travel.

* I certify that my request for mileage reimbursement is for miles accrued while working for Northwest Kidney Centers and while using a personal vehicle.

* I acknowledge that I have a valid Driver's License, that my personal vehicle is insured, and that Northwest Kidney Centers is not responsible for damages or injuries incurrred when I use my personal vehicle.

Travel Policy HRP-T590
Personal Vehicle Policy HRP-U606