

AMERICAN HEALTH CARE ASSOCIATION / NATIONAL CENTER FOR ASSISTED LIVING

1201 L Street, NW, Washington, DC 20005

MEMBER TRAVEL REIMBURSEMENT REQUEST

PLEASE PRINT

Name: _____

Company _____

Mailing address for reimbursement:

Work Phone () _____

Cell Phone () _____

Committee Name _____

Meeting Date(s) _____

Meeting Location _____

MEETINGS OFFICE APPROVAL:

Staff Liaison: _____ Date: _____

Meetings Liaison: _____ Date: _____

Account Code#: _____

Vendor #: _____

PER DIEM (Please check one):

See meeting notice for authorized number of days

_____ (Outside Washington, DC \$175/day) \$ _____

_____ (Inside Washington, DC \$200/day) \$ _____

\$30 if overnight is not required to attend meeting \$ _____

TRAVEL (Please check one):

Travel not to exceed maximum air travel reimbursement amount designated for each state.

Check if you booked with Orbitz for Business Travel

Attach travel receipts \$ _____

Travel by car: _____ miles @ 55.5¢/mile \$ _____

*(attach copy of directions and map showing miles traveled
i.e., Mapquest, Google Maps, Rand McNally)*

Other *(brief description with prior approval required)*

_____ \$ _____

TOTAL \$ _____

Signature of Traveler

Date