ASCENSION ST. JOHN HOSPITAL

SPEAKER EXPENSE REPORT

Name _____ Phone _____

Activity _____ Date of Activity _____

To reimburse you for expenses incurred for the above indicated activity, you are asked to complete and sign this report, attach all receipts, and use the enclosed pre-addressed envelope. We must receive this report no later than two weeks after the activity date to process a Travel Expense Report.

Expenses	Date	Amount
Total meals and tips *(Attach receipts.)*		
Round trip air fare — ATTACH ORIGINAL TICKET OR ELECTRONIC TICKET RECEIPT		
Taxi and/or limousine - (*Attach receipts)*		
Tips (other than meals)		
Parking/storage –(*Attach receipts)*		
Lodging — *ATTACH ORIGINAL HOTEL FOLIO*		
Other — *ATTACH EXPLANATION AND RECEIPTS*		
Auto mileage at .55 cents per mile		

TOTAL EXPENDITURE $_____

I certify that all items of expense included in this report were incurred in the discharge of authorized official business pertaining to the above named activity. The amounts are correct and represent proper charges to the ASCENSION ST. JOHN HOSPITAL for Medical Education. I further certify that payment has not been received from other sources for my portion of these expenses.

_____

Payee's Signature Date

Revised 12/10/2018