

UNIVERSITY MEDICAL CENTER TRAVEL EXPENSE REPORT FORM

No. _____

NAME: _____ DATES OF TRAVEL: _____ From/To _____

DEPARTMENT NAME: _____ COST CENTER: _____

Note: "Original Receipts Required"

PURPOSE OF TRIP: _____ SUB ACCOUNT #: _____ EXTENSION: _____

DESCRIPTION	Sun. (/ /)	Mon. (/ /)	Tues. (/ /)	Wed. (/ /)	Thurs. (/ /)	Fri. (/ /)	Sat. (/ /)	TOTAL
1 AIR FARE								
2 HOTEL								
3a AUTO RENTAL								
3b TAXIS								
3c LIMOUSINE SERVICE								
4 PARKING/TOLLS								
5 MILES X IRS RATE								
6 SEMINAR/REGISTRATION FEE								
7 MEAL EXPENSES								
8 TELEPHONE USAGE <small>(miscellaneous expense)</small>								
9 MISCELLANEOUS								
10 TOTAL FOR EXPENSE REPORT (Line 1-9)								
11a LESS CASH ADVANCE BY HUMC								()
11b LESS AMOUNTS CHARGED TO CORPORATE CREDIT CARDS								()
12a TOTAL DUE TO EMPLOYEE								
12b TOTAL DUE FROM EMPLOYEE								

Business Entertainment (Detail from Row 7)

DATE	MEETING PLACE	NAME OF FIRM & AFFILIATION OF PERSON ENTERTAINED	BUSINESS PURPOSE	AMOUNT

Employee Signature _____ Manager's Signature: _____

UNIVERSITY MEDICAL CENTER

Administration Authorization _____