INDIANA SOCIETY OF MEDICAL ASSISTANTS

EXPENSE VOUCHER

SUBMIT TO: Rita Michel, CMA (AAMA)
6710 W 600 N
Huntington, IN 46750-8874

ISSUE PAYMENT TO

NAME: _____

ADDRESS: _____

_____

Date of Expense: _____Date of Request _____

Date Paid: _____ Check Number: _____

Budgeted Item? ____ Yes ____ No (If not budgeted, expense must be approved)

Receipt(s) Attached? ____ Yes _____ No

RECEIPTS MUST BE ATTACHED FOR REIMBURSEMENT TO BE MADE:

COMMITTEE/OFFICE	PURPOSE OF EXPENSE	AMOUNT
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
	TOTAL	$_____

Submitted by: _____

Check # _____ Issue Date: _____

Notes: _____
_____