INDIANA SOCIETY OF MEDICAL ASSISTANTS
EXPENSE VOUCHER

SUBMIT TO:

Heidi J. Sisson, CMA (AAMA)
1007 Amesbury Ct.
Indianapolis, IN 46217-5364

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:

_____

_____