CALIFORNIA MEDICAL ASSOCIATION ALLIANCE

Reimbursement Form For State Board Officers/Committee Members and County Leaders

Submitted by:

Name: _____ Email: _____

Address: _____

_____

State Board/Committee/County Leader Position: _____

Please include receipts/copies of bills

General Expenses	**Explanation(s) (Please subtract any donations* from the total amount: Please specify position or general meeting charge)**	**Amount**
Postage		
Copies		
Printing		
Supplies		
Publications		
Travel/Parking/Tolls		
Donation*	Less *	
	Total General Expenses:	
Travel Expenses		
Check Meeting Attended	Winter Board _____ Summer Board _____ Annual Meeting _____ Affiliate Alliance Visit _____	
Date:		
Airline/Train/Bus Fare		
Mileage	(# of miles X $0.565)	
Bridge Toll		
Parking Fees		
Taxi/Shuttle		
Donation*		

Receipts must be attached for reimbursement.

Mail to: Nancy Schneider 1017 W. Lincoln Road, Stockton, CA 95207

Reimbursement Forms Must be Submitted Within 45 Days of Meeting

Revised 1/20/18