EMPLOYEE EXPENSE REIMBURSEMENT FORM

Sun Health EMPLOYEE SERVICES

***BACK UP DOCUMENTATION MUST BE SUBMITTED WITH THIS FORM.

NAME: **Campus:** SH Colonnade-630 **Date:**

MILEAGE, MEALS AND OTHER CHARGES							CODING				
DATE	DESCRIPTION	TRAVEL Miles	Rate/Mile $0.655	MEALS	OTHER	AMOUNTS DUE	CAMPUS	CARE TYPE	DEPT #	G/L ACCOUNT	
			$0.00			$0.00					
			$0.00			$0.00					
			$0.00			$0.00			