

**ONTARIO NURSES ASSOCIATION
LOCAL 055 Site: _____
EXPENSE REIMBURSEMENT FORM**

Member Name: _____
 Member Address: _____

 City: _____
 Postal Code: _____
 Phone Number: _____

Invoice / Reference #: _____
 (Local Treasurer use only) _____
 Date Submitted: _____

 Operating Account _____
 Discretionary account _____

ALL RECEIPTS MUST BE ATTACHED TO THIS FORM FOR REIMBURSEMENT

Meals				Daily Limit:	Account Code (Local Treasurer use only)
Date	Meal	Reason	Total		

Mileage					Per KM:	Account Code (Local Treasurer use only)
Date	From/To	Transport Method	KM (if applicable)	Reason	Total	
					-	
					-	
					-	

Accommodation				Account Code (Local Treasurer use only)
Date	Hotel	Reason	Total	

Other Costs				Account Code (Local Treasurer use only)
Date	Description	Reason	Total	

Member's Signature: _____
 Date: _____

Total Reimbursement: _____

Authorizing Signature: _____
 Date: _____

Date Paid: _____

Authorizing Signature: _____
 Date: _____

Cheque Number: _____