

Name: _____
 Organization: _____
 Address: _____
 City: _____
 State: _____ Zip: _____
 Phone: (_____) _____

Safety Pharmacology Society

Expenses Reimbursement Request



Period Covered: From: _____ 20____

To: _____ 20____

Travel Authorized By: _____

PURPOSE OF EXPENSE (Activity, Committee, Etc.)	ROUTE COVERED			MODE OF TRAVEL*
	DATE	FROM	TO	

DATE	TRAVEL	LODGING	MEALS			MISCELLANEOUS				TOTALS
			BREAK	LUNCH	DINNER	CABS	TEL	TIPS	OTHER	
Total										

OTHER EXPENSES (Explanation of Other Miscellaneous Above)

DATE	PURPOSE	AMOUNT

FOR ACCOUNTING ONLY		
Charge \$	To Line Item	Acct. NO.
Charge \$	To Line Item	Acct. NO.
Charge \$	To Line Item	Acct. NO.
Charge \$	To Line Item	Acct. NO.
EXTENSIONS AND TOTALS CHECKED INITIALS		POLICY CHECKED INITIALS

REIMBURSEMENT SUMMARY	
TOTAL EXPENSES	\$
LESS: ITEMS PAID BY OR CHARGED TO STP	()
REIMBURSEMENT DUE	\$

I hereby certify that the above expenses were incurred by me in connection with travel on SPS business and that I have not been, nor do I expect to be, reimbursed from another source for any portion of the net amount claimed from SPS.

SIGNED: _____ DATE: _____ APPROVED: _____ DATE: _____

**If personal car, indicate mileage, reimbursed at \$.555 per mile (Effective as of July 01, 2011).*