LA RONGE EMS

Caring for the North

Expense Form

Name: _____

Date: _____

Type of Claim: *Please check all that apply*

Medical ☐ Travel ☐ Reimbursement ☐

Travel

Departure	Destination	Mileage (Km x rate)		Total Payable
_____	_____	_____	X $0.521	$_____
_____	_____	_____	X $0.521	$_____

Medical

Departure Date _____

Return Date _____

Type of Claim (i.e. Dentist) _____

Reimbursement

Date	Type	Amount
_____	_____	_____
_____	_____	_____

Total Due $ _____

Signature: _____

All forms must be accompanied by a receipt

FOR OFFICE USE

Date of Payment: _____

Initial: _____