NYSCHP | New York State Council of Health-system Pharmacists
REIMBURSEMENT FORM

Date Submitted: _____

Submitted by:

Name _____

NYSCHP Position _____

Address _____
(City, State, Zip Code)
_____

Email _____

Section A

Item	Description	Amount
Postage		$
Supplies		$
Printing		$
Telephone		$
Other (describe)		$
	Total	$

Section B

Reason for travel:

Item	Description	Amount
Auto	(Include miles, round trip or one way) ($0.67 mile rate)	$
Parking		$
Taxi/Uber/Lyft		$
Tolls		$
Hotel	(Include # of nights)	$
	Total	$

Section C

Meals

Item	Description	Amount(s)
Meal (Self)		$
Meal (Group)	IList the name of all attendees)	$
Gratuities		$
	Total	$

Note

Reimbursement will be provided for authorized expenditures if a reimbursement request, plus receipts, is submitted within 30 days of occurrence.

Submit to office@nyschp.org