FLORIDA HEALTHCARE ENGINEERING ASSOCIATION

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• Email sarah@fhea.org • www.fhea.org

TRAVEL VOUCHER

NAME: _____ FACILITY: _____
ADDRESS: _____ TELEPHONE: _____
CITY: _____ STATE: _____

Date: _____ From: _____ To: _____
Date: _____ From: _____ To: _____

Organization Business/Explain: _____
_____

District No: _____ Current Office Position: _____

Transportation:
Air _____ $_____
Auto _____ Mileage @ per mile _____ $_____
Hotel Accommodations $_____
Meals/Food (Details Below) $_____
Other Expenses (Detail Below) $_____
(Tolls, Taxi, Parking Fees, Etc,)
TOTAL REIMBURSEMENT: (Attach Receipts) $_____

MEAL EXPENSE DETAIL				
DATE	BREAKFAST	LUNCH	DINNER	TOTAL
	$	$	$	$
	$	$	$	$
	$	$	$	$

OTHER EXPENSE DETAIL		
DATE	REASON	TOTAL
		$
		$
		$
		$
		$
		$
		$
		$
		$
		$
	OTHER EXPENSE TOTAL	$

Signature of Traveler: _____
Approved: _____ _____
State President State Secretary or Treasurer
Check No. Issued: _____ Date Issued: _____

Revised 11/17