

**Kentucky Medical Association Alliance
Expense Reimbursement Voucher**

NAME _____ DATE _____

ADDRESS _____ COMMITTEE _____

City, Zip _____

BOARD POSITION _____

OPERATING EXPENSES:

Phone _____ Postage _____

Printing _____ Supplies _____

Other (specify) _____

TRAVEL EXPENSES:

Dates of Travel _____ Destination _____

Purpose of Travel _____

Airfare _____ Ground Transportation _____

Hotel _____ Food _____

Auto: #of miles traveled _____ @ _____ cents/mile = \$ _____ total

Tolls _____ Other (specify) _____

GRAND TOTAL AMOUNT DUE: \$ _____

COMMENTS: _____

***Travel Expenses apply to President and President-Elect only, unless incurred as a Delegate representing our State per KMAA By-Laws and Policies.**

Please attach all receipts (or copies of same) and remit to:

**Jo Ann Daus, KMAA Treasurer
1305 Killiney Place
Louisville, KY 40207**