



# EXPENSE REPORT

## EMPLOYEE INFORMATION

Last Name	First Name	Date
Address		City, State, Zip
		Phone

Your expense check will be included with your next payroll check.

## ASSIGNMENT INFORMATION

Hospital	Location	Dates

## MILEAGE DETAILS

This section must be completed to receive reimbursement for mileage.

<b>Dates of Travel</b>	
Begin Odometer Reading	
End Odometer	
Total Miles	
x \$.040 = <input type="text"/>	
Transfer this amount to subtotal at right.	
<b>Location of Travel</b>	
From	
To	

Date	Description/Purpose/Name	Total
1.		
2.		
3.		
4.		
5.		
<b>(from left) Mileage Reimbursement Subtotal:</b>		
<b>GRAND TOTAL:</b>		

## AUTHORIZATION

I hereby certify that the expenses listed above are a true and accurate account of my expenses and in compliance with Advantage RN policies.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Approval Signature \_\_\_\_\_ Date \_\_\_\_\_

**Note:** Original receipts are required to issue expense reimbursement checks. Expense reports not accompanied with the original receipts may be denied. Please allow four weeks to receive expense checks.

**Mail original reports and receipts to your Recruiter, or:** Advantage RN, Attn: Accounting, 8892 Beckett Rd., West Chester, OH 45069

**Mileage Only Expense Reports** can be faxed directly to Accounting at 866-850-4048.