WACBD Expense Reimbursement Request Form

Employee/Individual Information:

Name:	Employee ID:
Home Address:	Phone No:
City, State, Zip:	Department:

Business Purpose for Expense:

☐ Supply (Office/Patient) ☐ Parking ☐ Staff Training or Professional Development ☐ License Renewal ☐ Other

Did you attach your expense receipts? ☐ Yes ☐ No **(please include signed missing receipt forms in your request.)**

Item	Purchase Date (mm/dd/yy)	Vendor	Description/Detail	Amount
1				
2				
3				
4				
5				
6				
7				
8				

Total Reimbursement: $ 0.00

I certify I received prior approval to make this expense purchase and have attached approval documentation.

I certify this claim for reimbursement of expenses is true and correct, all expenses listed were actually incurred by me as necessary to perform my job responsibilities on behalf of the Washington Institute for Coagulation d/b/a WACBD.

I certify I have not been nor will be reimbursed for any of these expenses from another source and these expenses were not prepaid by a WIC credit card.

Employee/Individual Signature: _____ Date: _____

Supervisor/Authorized Signature: _____ Date: _____

TO BE COMPLETED BY ACCOUNTING ONLY:

Grant: ☐ CDC ☐ HRSA ☐ Other	Expense GL Code: ☐ 6300 ☐ 6310 ☐ 6820 ☐ 7100 ☐ 7110 ☐ 7340 ☐ 9900	Revenue GL Code: