

EXPENSE REPORT 2006/2007

On Assignment Nurse Travel



NAME: _____

DATE: _____

ADDRESS: _____

PHONE: _____

SS#: _____

PLEASE ALLOW 2 WEEKS TO RECEIVE ANY REIMBURSEMENTS

******ORIGINAL RECEIPTS AND SIGNATURE REQUIRED-INCOMPLETE REPORTS WILL BE DENIED******

Note: Original Receipts cannot be returned due to Company Policy

	Date	Description/Name	Total	GL Account Code For Office Use Only
1				
2				
3				
4			\$	
5			\$	

SUBMITTED BY (EMPLOYEE): _____ DATE: _____

SIGNATURE

Subtotal	\$		
TOTAL	\$		
Assignment Hospital:			
Assignment Dates: / / to / /			

ON ASSIGNMENT MANAGEMENT: _____ DATE: _____

SIGNATURE



Note: The entire section below must be completed to receive mileage reimbursement



From: (Address) To Destination: (Address)	★ Dates of Travel ★	Beginning Odometer	
	/ /	Ending Odometer	
	/ /	Total Miles x 0.375	\$

★ **Original reports and receipts must be mailed to: Attention Karen Holthaus @ On Assignment Nurse Travel, 8150 Corporate Park Dr., Suite 300, Cincinnati, OH 45242.**

★ **Only Documents accepted by fax #1-877-546-7044 are:** Expense reports for mileage, the front and back of a cancelled check for licensure reimbursement, or a copy of a complete invoice/bill instead of a receipt.

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★ **Only authorized expenses will be paid, these do not include meals, fuel, shipping fees, etc.**