



CALIFORNIA ASSOCIATION OF ORTHODONTISTS EXPENSE REPORT

401 North Lindbergh Blvd. St. Louis, MO 63141

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Phone: 888-242-3934 X 592

Fax: (314) 993-6843

(Please Attach Copies of Receipts For All Expenses)

Name _____ Remittance Address _____

Destination _____

Meeting/Purpose _____

NOTE:	Please submit requests for reimbursements within 30 days. We regret that we will be unable to honor reimbursement requests received after the end of the calendar year in which expenses are incurred
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Date (mo/day/yr)	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Weekly Total
Hotel								
\$50 Daily Per Diem								
Airfare								
Taxis/Buses								
*Mileage @ .51								-
Parking/Tolls								-
								-
								-
								-
TOTALS	-	-	-	-	-	-	-	-

LESS: PERSONAL DEDUCTIONS:

Meals (e.g. spouse) _____

In-Room Movies _____

Other _____

BALANCE DUE TO CAO MEMBER -

Signatures:

CAO Member _____ Date _____

Executive Director _____ Date _____

Additional Comments

***List to and from business travel destinations for any mileage listed above**
