DMAT SAN DIEGO CA-4
Dept. of Emergency Medicine
UCSD Medical Center
200 West Arbor Drive
San Diego, CA 92103-8676
Tel.: (619) 543-6216
Fax.: (619) 543-3115
eMail Address: ca4cdr@san.rr.com

EXPENSE REIMBURSEMENT FORM #1 (Non-Travel)
(Must Attach Receipts)

Print Name: _____ **SSN:** _____

Date of Request: _____

I hereby request reimbursement for the following Pre-authorized expense(s) incurred for the following event:
(Name of event)_____

I understand that DMAT CA-4 will refund such expenses up to the amount authorized in the budget. Any expenses over and above that amount will be my own responsibility.

Item #1: _____
Name of vendor from whom item purchased: _____ Date: _____
Amount: $ _____

Item #2: _____
Name of vendor from whom item purchased: _____ Date: _____
Amount: $ _____

Item #3: _____
Name of vendor from whom item purchased: _____ Date: _____
Amount: $ _____

Total: $ _____

Receipts are attached.
Method used for payment of expense: (Select One): Select One
Please mail reimbursement check to me at the following address:
Street address:
City:
State:
Zip+4:
Tel.:

I certify this is a true accounting of my actual expenses.
Signature:_____

Please forward completed form along with all receipts to the following address:
DMAT SAN DIEGO CA-4
ATTN: Jake Jacoby, MD
200 West Arbor Drive
San Diego, CA 92103-8676