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

TRAVEL EXPENSE REIMBURSEMENT FORM #2
(Must Attach Receipts)

PRINT NAME: _____ **SSN:** _____

DATE OF REQUEST: _____ ;

DATE OF DEPARTURE: _____ ;

DATE OF RETURN: _____
I hereby request reimbursement for the following travel expense(s) incurred for the following event:

(Name of event): _____

I understand that DMAT CA-4 will refund such travel expenses up to the amount authorized in the budget, or in the CA-4 announcement for this event. Any expenses over and above that amount will be my own responsibility.

TRAVEL FROM HOME TO LOCAL AIRPORT AND BACK HOME ON RETURNING: **RT MILES:** _____

LODGING: [Must attach original hotel receipt] **AMOUNT: $** _____

AIR OR TRAIN FARE: [Must attach original airline or train receipt] **AMOUNT: $** _____
IF TRAVELED BY POV (PERSONALLY-OWNED-VEHICLE), PROVIDE TOTAL MILEAGE INSTEAD: **RT MILES:** _____

INCIDENTAL TRAVEL: [Attach original Taxi/Shuttle/Bus receipt(s)] **AMOUNT: $** _____

MISCELLANEOUS EXPENSES:

EXAMPLE: MEETING REGISTRATION FEES; [must be pre-approved] **AMOUNT: $** _____

TOTAL: $ _____

Receipts are attached.
Dear DMAT CA-4 Administrative Officer,
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