*Place Image of Practice Logo Here*

**Reimbursement / Expense Form**

Staff Name: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date Requested: \_\_\_\_\_\_\_\_\_\_\_

*Include disclaimer, limitations and/or special instructions here. Examples:*

* *Reimbursement limitation*
* *Deadline to submit request*
* *Time expected to receive reimbursements*

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| **Date of Expense** | **Description of Expense** | **Expense Amount** |
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|  | **Total Amount** |  |