CoreMEDICAL GROUP℠
The Best in Healthcare Staffing

PLEASE COMPLETE & RETURN VIA FAX TO: 1-877-405-0793 OR 1-888-631-8777

Expense forms AND applicable receipts must be received by **Fridays at Noon** in order to be processed for the following week's payroll cycle.

Contractor Travel Summary/Expense Reimbursement Report

Name: **Facility:** **Date:**

TRAVEL TO AND/OR FROM ASSIGNMENT:

DATE(S) of TRAVEL	CITY & STATE TRAVELED FROM (Beginning Location)	CITY & STATE TRAVELED TO (Arriving Destination)	NUMBER OF MILES	CMG MILEAGE RATE	TOTAL MILEAGE AMOUNT $
				0.50	

DATE	EXPENSES (Including Licensure, Tolls, Misc)	LICENSURE	TOLLS	CAR RENTAL	MISC.

MILEAGE

HOME HEALTH VISITS AND TRAVEL BETWEEN FACILITIES

Mileage reimbursement requires an approval signature from the facility

DATE		NUMBER OF MILES PER DAY	MILEAGE RATE	TOTAL
			TOTAL	

* If receipts cannot be provided, the reimbursement must be taxed. Also, expense reimbursement requests MUST be received within 30 days of occurrence. We cannot accept requests after this period has expired. However, with regard to licensure reimbursement, this reimbursement will take place after you have begun your assignment.

* MILEAGE RATE: Your contract will specify if you are allowed mileage for travel between facilities or for home health visits and what the rate is.

Mileage reimbursement requires an approval signature from the facility.

I certify that I have incurred these expenses for work related purposes and I have attached all receipts as backup.

Date: _____ **Employee Signature:** _____

Date: _____ **Facility Approval:** _____

Toll Free Phone: 800-995-2673 **Toll Free Fax: 877-405-0793 or 888-631-8777**