ORTHOPAEDIC SECTION, APTA, INC
2920 EAST AVENUE SOUTH, Suite 200, LA CROSSE WI, 54601 800-444-3982 FAX 608-788-3965
REIMBURSEMENT REQUEST

Name:_____
(PLEASE PRINT)
Meeting: _____
Date: _____ **Place:** _____

Reimbursement is on the basis of actual hotel expenses (room and tax) plus actual travel costs (plane, train, bus) and actual local ground transportation. Hotel reimbursement will not exceed the single room rate at the convention hotel(s). Airfare reimbursement is based on coach fare of $470.00. Anything above this amount requires approval by the Executive Director. Mileage will be reimbursed at .575/mile. Per diem is limited to $36.00 per day, UNLESS receipts are attached, whereupon, per diem will be reimbursed UP TO $65.00 per day. Any meals provided by the Section will be deducted from your reimbursement as follows: $15 for breakfast, $20 for lunch and $30 for dinner. All reimbursements for expenses need to be submitted within 60 days to receive 100% of allowable expenses. Requests for reimbursement received after 60 days will only be reimbursed up to 75% of the total allowable expenses.

DATE	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	TOTAL
TRAVEL								
Auto mileage $ .575 /mile x .575 miles								
Airfare								
Taxi								
Parking/Tolls								
LODGING/MEALS								
Hotel Single room rate								
Meals								
TOTALS								
Office use only								

I certify that this travel expense report is correct and that these expenses are not being submitted for reimbursement to any other organization:
Today's date: _____

Name: (please print): _____

Signature_____SS#_____

Phone: ( ) _____

Mail check to: _____

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(updated 6/26/06, 10/24/08, 3-16-09, 1-7-10, 6-21-11, 7-8-11, 2-24-12, 9-1-15 by TKF)