CITY OF MEDFORD
PERSONAL REIMBURSEMENT FORM

Date of Request: _____

NAME/TITLE OF PERSON BEING REIMBURSED: _____

DEPARTMENT: Health Department TITLE: _____

REASON FOR EXPENSE: _____ **Instate or Out-of-State Travel**: Y or N
Check Y or N here --> ☐ ☐

DATE OF FUNCTION/PURPOSE: _____ (if this covers Instate or Out-of-State Travel, please be sure to provide receipts for hotel, flights, transportation, tolls, meals, etc.)

When meals or expenses are provided by the event organizer and/or included in the seminar, please provide said information by copy of the itinerary, brochure, etc.

VENDOR #:_____ ACCOUNT #:_____
(CANNOT PROCESS THIS FORM WITHOUT THE VENDOR/ACCOUNT NUMBERS)

ITEMS PURCHASED: _____

_____

WHERE PURCHASED: _____

AMOUNT OF REFUND: $_____

_____ _____
Signature of Person Applying for Reimbursement Date

_____ _____
Department Head Signature for Approval (or Designee) Date

ORIGINAL RECEIPT(S) MUST ACCOMPANY THIS FORM