



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, Car Rental, Tolls, Misc)	LICENSURE	TOLLS	CAR RENTAL	MISC.

DATE	MILEAGE		NUMBER OF MILES PER DAY	MILEAGE RATE	TOTAL
	HOME HEALTH VISITS AND TRAVEL BETWEEN FACILITIES				
	Mileage reimbursement requires an approval signature from the facility				
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:** _____