

# HFMA

## Wisconsin Chapter of HFMA Expense Voucher

Date: \_\_\_\_\_

\_\_\_\_\_

Pay to: \_\_\_\_\_  
Name \_\_\_\_\_

\_\_\_\_\_ Your E-Mail Address

\_\_\_\_\_ Your Telephone No.

\_\_\_\_\_ City State Zip

<u>Date</u>	<u>Destination/Purpose</u>	<u>(July 1, 2008 - Dec 31, 2008)</u>		<u>Expense Category to Charge</u>
		<u>Miles</u>	<u>Amount</u>	
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

<u>Date</u>	<u>Other Expenses (see attached receipts)</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Total to be reimbursed (mileage & other expenses) \$ \_\_\_\_\_

Your Signature: \_\_\_\_\_

Date Paid: \_\_\_\_\_ Check Number: \_\_\_\_\_

**Mail expense form and receipts to:**  
**Arthur E. Mertig**  
**Memorial Medical Center, Inc.**  
**1615 Maple Lane**  
**Ashland, WI 54806**  
[amertig@ashlandmmc.com](mailto:amertig@ashlandmmc.com)