aarc
American Association for Respiratory Care

Expense Reimbursement Form

Paid To The Order Of:	
Phone:	
Email:	
Check Payable To:	
Mailing Address:	
City, State, Zip:	

COMPANY	
AARC	☐
ARCF	☐
DAED	☐
PAYMENT TYPE	
E - Payment	☐
Check	☐

Description of Usage / Reason for Reimbursement:

Itemized Expenses

Attach Receipts. Circle the date & amount on each receipt. For partial receipts, circle the items & write the total on the receipt

DESCRIPTION	ACCOUNT NUMBER	PREPAID BY COMPANY	QTY	AMOUNT
AIRFARE				
LODGING (ROOM & TAX ONLY)				
PER DIEM ($70.00 PER DAY)				$ 0.00
MILEAGE ($0.67 PER MILE)				$ 0.00
TAXI/UBER/SHUTTLE, ETC.				
	TOTAL TO REIMBURSE	$ 0.00		$ 0.00

Requestor Signature **Date**

Approval

Approved By (Name) Position Signature Date