Uintah Basin Medical Center

Travel Reimbursement Request

Name_____ Date of Request_____

Destination_____ Length of Stay _____

Purpose_____ Date(s) absent from work_____

Expenses			Amount Charged to Hospital	Amount Paid by Traveler
Transportation	Airplane			
	Personal Vehicle (53 cents per mile)	# of Miles Traveled		
	Other			
Room:				
Meals:				
Registration Fees:				
Other: (please explain)				
Totals:				
Total Cost of Trip:				
Less Advance and Hospital Payment:				
Amount Paid to Employee:				
Advance Payment Requested: (estimate)				

Make check payable to:_____ Telephone:_____

1. All travel must be approved by the department's administrative liaison prior to the date of travel
2. An advancement of funds can be requested when appropriate. The maximum amount of advance payment must be less than 90 percent of estimated costs excluding the mileage allowance.
3. Travel arrangements should be directed through Stacey Holgate including hotel stay, airfare, care rental, etc.
4. A final travel request must be submitted with receipts before final reimbursement will be made.
5. Mileage will not be reimbursed until after the trip.
6. Mileage at the rate of 53 cents per mile may not exceed the cost of round trip coach airfare.
7. Exceptions must be approved by Administration in advance.

_____ _____ _____

Department Manager | Assistant Administrator | Administrator (If over $200)