Central New England Region

Clinician/Official Expense Form

To be completed and submitted by clinician or official prior to payment.

Name:_____ **Date:**_____

I request payment and/or reimbursement for amounts expended by and/or due to me in conjunction with the following:

Activity:_____ **Date:**_____

Fee: **$:**_____

Travel:

Mileage_____ @ $.25 Per Mile $_____

Tickets (with receipts) $_____

Parking, Tolls, Ect. $_____

Other (explanation)_____

_____

_____ $_____

I wish to donate this amount back to CNER - **$**_____

TOTAL **$**_____

Organizer Signature:_____

Signature:_____

Address:_____

_____

Submit to: Treasurer

Laura Smith

3 Woodland Road

North Hampton, NH 03862

✶ Please be advised: If your fees to CNER within the calendar year total $600 or more, your social security #_____ will be required for 1099 purposes.