FPTA EXPENSE REIMBURSEMENT REQUEST

Please return when complete to:
800 N Calhoun St #1A
Tallahassee, FL 32303
Fax 850/224-5281

Name of Reimbursement Recipient _____

Recipients Mailing Address _____

City _____ State _____ Zip Code _____

Date/Date Range of Expenses Incurred_____ Year_____

Reason for Expense(s)

_____

_____

ITEMIZATION OF EXPENSE REIMBURSEMENT REQUEST

Date of Expense	**Airfare**	**Lodging**	**Mileage - .54/mile**	**Meal Expense**	**Other – Identify**
TOTAL					

(Attach actual receipts or copies that meet or exceed reimbursement amounts requested)

TOTAL AMOUNT OF EXPENSE REIMBURSEMENT REQUESTED $_____

RELATIONSHIP TO FLORIDA PHYSICAL THERAPY ASSOCIATION:

☐ BOARD OF DIRECTORS ☐ FPTA COMMITTEE MEMBER ☐ FPTA STAFF
☐ SPEAKER/PRESENTER ☐ CONSULTANT ☐ VENDOR

☐ REFUND FOR :_____

Signature of person seeking Reimbursement _____

Approved by _____

FPTA ☐ Panel Coordinator ☐ President ☐ Treasurer, on {Date} _____/_____/_____

Reimbursement Approved for payment by Executive Vice President on {Date} _____/_____/_____

Approved by Executive Vice President _____

MUST BE SUBMITTED WITHIN 45 DAYS OF EXPENSES INCURRED FOR PROCESSING