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| **EXPENSE REPORT** | | | | | | | | | | |
| **Activity:** | |  |  |  |  |  |  |  |  |  |
| **Name:** | |  |  |  |  | **Date:** |  |  |  |  |
| **Address:** | |  |  |  |  | **Email:** |  |  |  |  |
| **City/State/Zip** | |  |  |  |  | **Phone:** |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **This request for reimbursement is being sent for the following items:** | | | | | | |  |  |  |  |
|  | Item or expense: | | | | | Amount | Totals |  |  |  |
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Email with receipts to [kimberlysutton@texashealth.org](mailto:kimberlysutton@texashealth.org) within 30 days of event

I certify that this accounting is accurate as to actual and necessary business expenses incurred.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

APIC DFW Use only:

Approved:

Date Paid: