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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 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: