

**Public Employees Local 71 Trust Fund
Travel Expense Voucher**

Member Name: _____ **Patient Name:** _____

Member Alternate ID or SSN Number: _____

Transportation:

Date of Departure: _____ Date of Return: _____

- ☐ Private Automobile _____ miles at \$0.45 per mile \$ _____
- ☐ Airfare (attach copy of ticket) \$ _____
- ☐ Ferry (attach copy of ticket) \$ _____
- ☐ Cab Fare (attach copy of ticket) \$ _____

Lodging:

Date of Check-in: _____ Date of Check-out: _____

- ☐ Hotel or Motel Expense (attach copy of bill) \$ _____

Food: All food expenses must be supported by a receipt.

Date:	____/____/____	____/____/____	____/____/____
Breakfast:	\$ _____	\$ _____	\$ _____
Lunch:	\$ _____	\$ _____	\$ _____
Dinner:	\$ _____	\$ _____	\$ _____
Total:	\$ _____	\$ _____	\$ _____

Date:	____/____/____	____/____/____	____/____/____
Breakfast:	\$ _____	\$ _____	\$ _____
Lunch:	\$ _____	\$ _____	\$ _____
Dinner:	\$ _____	\$ _____	\$ _____
Total:	\$ _____	\$ _____	\$ _____

TOTAL OF ALL DAILY FOOD EXPENSES: \$ _____

Total of Transportation Expense Voucher Request: \$ _____