COMPANY EXPENSE REIMBURSEMENT FORM

IDENTIFICATION

Employee Name:	**Phone:**
Social Security Number:	**Date:**
Employee Number:	**Email:**
Position/Title:	**Dept:**

WORK RELATED EXPENSES

Date	Description	Amount
	TOTAL EXPENSES TO BE REIMBURSED	

All expenses should be supported with copies of invoice, receipt, or other identifying information.

I certify that the statement and information on this reimbursement form are accurate and true. I also certify that I am claiming reimbursement for only eligible expenses incurred during the plan year and only for eligible plan participants. I certify that these expenses have not been or will not be reimbursed under this or any other plan. I further certify I will not claim these, or any other expenses reimbursed through this plan, as an income tax deduction and I assume all liability for taxes and penalties out of any disallowed deduction/credit.

Employee Signature: _____ Date:_____

FOR ADMINISTRATIVE USE ONLY

Reviewed By:_____ Date:_____ Approved: $_____ Denied: $_____

Reason for Denial: _____ Action: _____