

ASSOCIATION FOR CLINICAL PASTORAL EDUCATION, INC.
Pacific Region

Name: _____

Date: _____

Address: _____

ACCREDITATION COMMITTEE – SITE VISIT (please list site and dates)

TRAVEL

Date								
Auto/Miles Driven @ ____								
Airfare								
Parking/Tolls								
Other								
Transportation Total								

FOOD

Date								
Breakfast (\$10 max)								
Lunch (\$15 max)								
Dinner (\$30 max)								
Food Total								

LODGING – Double occupancy, standard room

Date								
Motel/Hotel								
Lodging Total								

MISCELLANEOUS

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Submitted by: _____
(Signature required by person submitting request)

Authorized by: _____
(Signature Required: Committee Chair, Regional Chair)

Date Paid: _____

Check # _____

SUMMARY

Transportation Total	
Food/Meals Total	
Lodging Total	
Miscellaneous	
Sub-Total	
Less Pre-Paid/Advance	
Total Expenses	

Receipts Required with this Form

Expense vouchers must be received within 60 days of the conclusion to Site visit/event.
Please send to the Regional Accreditation Chair & Pacific Region Office.