

**ASSOCIATION FOR CLINICAL PASTORAL EDUCATION, INC.
PACIFIC REGION**

Name: _____

Date: _____

Address: _____

CERTIFICATION COMMITTEE/FUNCTION

TRAVEL

Date								
Auto/Miles Driven @ ____								
OR Airfare								
Other								
Transportation Total								

FOOD

***MEALS ARE NOT PER DIEM – RECEIPTS REQUIRED**

Date								
Breakfast (\$10 max)								
Lunch (\$15 max)								
Dinner (\$25 max)								
Food Total								

LODGING

*** DOUBLE OCCUPANCY, STANDARD ROOM**

Date								
Motel/Hotel								
Lodging Total								

MISCELLANEOUS

--	--

Submitted by:

(Signature of person submitting the request)

Authorized by:

(Signature of Committee Chair– Approval Required)

Date Paid:

Check #

Authorized by:

(Signature of Regional Director)

SUMMARY

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

RECEIPTS REQUIRED
Attach receipts to Form

Form Updated 2014

Reimbursements must be received at the Regional Office no later than 30 days after the meeting.