



**Central New England Region**  
 Clinician/Official Expense Form

*To be completed and submitted by clinician or official prior to payment.*

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I request payment and/or reimbursement for amounts expended by and/or due to me in conjunction with the following:

**Activity:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Fee:** \_\_\_\_\_ **\$:** \_\_\_\_\_

**Travel:**

Mileage \_\_\_\_\_ @ \$. \_\_\_\_\_ Per Mile \$ \_\_\_\_\_

Tickets (with receipts) \$ \_\_\_\_\_

Parking, Tolls, Ect. \$ \_\_\_\_\_

Other (explanation) \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

I wish to donate this amount back to CNER - \$ \_\_\_\_\_

**TOTAL** \$ \_\_\_\_\_

**Organizer Signature:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

**Submit to: Treasurer**

**Curtis Renner**

**1108 Whittemore St.**

**Leicester Ma. 01524**

Ω Please be advised: If your fees to CNER within the calendar year total \$600 or more, your social security # \_\_\_\_\_ will be required for 1099 purposes.