



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.