

**CALIFORNIA MEDICAL ASSOCIATION ALLIANCE**  
**Reimbursement Form For State Board Officers/Committee Members and County Leaders**

**Submitted By:**

**Name:** \_\_\_\_\_ **E-Mail** \_\_\_\_\_

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

\_\_\_\_\_ **Phone** \_\_\_\_\_

**State Board Position/Committee:** \_\_\_\_\_

*Please include receipts/copies of bills*

<b>General Expenses</b>	<b>Explanation(s)</b> - (Please subtract any donations* from the total amount: Please specify committee or general meeting charge)	<b>Amount</b>
Postage		
Copies		
Printing		
Supplies		
Publications		
Telephone		
Travel/Parking/Tolls		
Donation*	Less*:	
	<b>Total General Expenses:</b>	
<b>Travel Expenses</b>		<b>Amount</b>
Check Meeting Attended	Incoming Board Retreat _____ Fall Conference _____ Winter Board _____ Annual Session _____ Other: Specify _____	
Date:		
Airfare		
Mileage	(# of Miles - _____ x \$0.43)	
Bridge Tolls		
Parking Fees		
Taxi/Shuttle		
Donation*	Less*:	
	<b>Total Travel Expenses:</b>	
	<b>Total Amount Requested for Reimbursement:</b>	

*Receipts must be attached for reimbursement. See reverse side for instructions*  
**Mail to: CMA Alliance - Treasurer**  
**1201 J Street, Suite 300, Sacramento, CA 95814**  
**Reimbursement Forms Must be Submitted Within 30 Days of Conference**