Print Form

St. Peter's Hospital
2475 Broadway • Helena, MT 59601
www.stpetes.org

TRAVEL REQUEST / EXPENSE FORM

Section 1

NAME: _____ **Account #** _____

DEPARTMENT: _____ **Foundation Reimbursement:** ☐ **Yes** ☐ **No**

Destination: _____ **Travel Dates:** _____ **to** _____

Purpose/Workshop: _____

Director/Supervisor Approval: _____ **Date:** _____

	Section 2	Section 3	Section 4
Description of Expense	**Estimated Total Expense for Travel (Completed by employee BEFORE travel)**	**Expenses Paid by Hospital Prior to Travel (Completed by Accounting)**	**Cash Advance Requested by Employee(Completed by Employee)**
Airfare			
Private Car miles @ _____ cents/mile* _____			
Car Rental			
Lodging			
Meals			
Registration			
Miscellaneous (i.e., cab fare, parking, telephone)			
Total Anticipated Expenses and Cash Advance			

*** Please refer to the Travel Expense Reporting policy for the current mileage reimbursement rate.**

Section 5 - TRAVEL EXPENSE / REIMBURSEMENT VOUCHER - (To be completed and returned along with appropriate receipts to accounting within five (5) working days after return from travel.

Dates of Travel →	/ /	/ /	/ /	/ /	/ /	/ /	**TOTAL**
Car - miles x cents per mile							
Car Rental							
Lodging (not prepaid)							
Meals							
Telephone							
Taxi/Parking							
Miscellaneous (please list)							
DAILY TOTALS Line 5a							

Less Cash Advance (from Section 4) → Line 5b ( )

Balance Due Employee _____ → Line 5c _____

OR

Balance Due Hospital → Line 5d _____

I certify the claim for reimbursement of expenses incurred by me for the travel outlined above is a true statement and that only those expenses necessary during this travel have been claimed.

Signature of Employee / Date

Approval / Date

Instructions for Completion of Travel Request/Expense Form

These instructions are provided to assist you in filling out the travel request and expense form. Please refer to the Travel Expense Reporting Policy for details about travel guidelines for St. Peter's Hospital.

Section 1

1. Please complete name, department, destination, travel dates, account number to be charged and purpose or workshop.
2. Please also include whether funding for this travel will be reimbursed by Foundation dollars.

Section 2 - Section 2 is used to estimate the total expenses for the trip. This section is to be completed by the Employee.

Please indicate the amount of expense anticipated for each item.

Section 3 - Expenses Paid by Hospital Prior to Travel

Section 3 is a breakdown of expenses prepaid by the hospital and is completed by the Accounting Department. These generally include lodging (if prepaid directly to the hotel) and registration and airfare. These items should not be included in the request for cash advance.

1. If an item is to be prepaid by the Hospital, such as registration fee or hotel, please request a check from Accounting. Please remember that you are responsible for registering and arranging for all the travel. The accounting department is only responsible for providing the monies once a request has been made.
2. This section will be completed by Accounting based on requests received to prepay expenses.

Section 4— Travel Advance Request

1. Please indicate the amount of travel advance requested for each item.
2. Do not request additional dollars if a request for pre-payment has previously been sent to Accounting.

Once Sections 1, 2 and 4 are completed, submit to your Supervisor or Director for approval. After approval, please send the back page (yellow copy) to the Accounting Department. Keep the top page. This will be filled out upon return from travel and submitted to accounting at that time.

Section 5 - Travel Expense/Reimbursement Voucher - Section 5 is to be completed within five working days upon return from travel.

1. Please list only daily expenses which you paid for and are requesting reimbursement. Do not include expenses which were PREPAID by the hospital. Total all expenses and list on Line 5a.
2. On Line 5b, put the total cash advance received prior to travel. This should match the amount indicated in Section 4.
3. Subtract the amount you received as a cash advance (Line 5b) from the total cost of expenses which you paid for (Line 5a). If the amount of expenses (Line 5a) is greater than the cash advance (Section 4), list on Line 5c. The amount noted on Line 5c will be repaid to you from the Hospital
4. If Line 5a is more than Line 5b or if you received a cash advance which exceeded your out of pocket expense, the amount noted on line 5d must be repaid to the Hospital. Please forward a check or money order payable to St. Peter's Hospital to the Accounting Department within five working days after return from travel.

Please sign and date the bottom of the form, submit to your Director/Supervisor for approval and forward to the Accounting Department.