**VOLUNTEER EXPENSES**

**REQUEST FOR REIMBURSEMENT FORM**

NAME:

ADDRESS:

CITY/STATE/ZIP:

DATE OF MEETING:

NATURE/PURPOSE OF MEETING:

EXPENSES: \* Miles x $0.585/mile

 \* Lodging Expenses (please attach receipt)

 \* Meal Expenses

 ***NOTE: Meal receipts must be presented in***

 ***order to be reimbursed.***

 Breakfast $14.00

 Lunch $16.00

 Dinner $26.00

 \* Other Expenses (please describe)

 TOTAL REQUESTED =

Amount

\_\_\_\_\_\_\_I choose to waive all or a portion of this request for reimbursement as an in-kind donation to Disability Rights Iowa.

\_\_\_\_\_\_\_Percentage waived

(SIGNATURE)

Fax to: 515-278-0539 or

Send to:

Disability Rights Iowa

400 East Court Avenue Suite 300

Des Moines, IA 50309

Revised 8/4/2015