**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