American College of Prosthodontists
211 East Chicago Ave, Ste.1000
Chicago, Illinois 60611
312-573-1260
312-573-1257 fax

MEMBER EXPENSE REIMBURSEMENT REPORT
(*One Report per Event or Activity*)

Name: ______________________________

Event or Activity: ______________________ Date(s): ______________

Itemized receipts for all items listed below must be attached to this report.

	Type	Amount	Explanation
653	**Airfare** *(Coach Only; $600 max unless approved)*		
654	**Lodging/Hotel**		
655	**Taxi/Shuttle/Ride Share***		
655	**Mileage*** @ 0.655/mi (IRS 2023 Rate – Rev.1.2023)		
655	**Parking & Tolls***		
655	**Other** -***Explanation Required*** *Meals (outside of BOD meetings**) $70 per day max with itemized receipts*		

**Ground transportation and parking costs max is $75 per trip with receipts*
****Meal costs outside of those provided during the meeting will not be reimbursed.*

Total Reimbursement Amount Requested = $________________

The undersigned agrees that this report is accurate and complete:

Signature:____ Date:_________________
(Individual Requesting Reimbursement)

Make Check Payable To:____

Mailing Address:____

____

ACP APPROVAL:____ DATE:__________________