



**2016 MSDA Symposium**  
**REGULAR Member Expense Reimbursement Form**

Name: \_\_\_\_\_

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

City, State and Zip: \_\_\_\_\_

SSN: \_\_\_\_\_

Meeting Dates: **June 12-14<sup>th</sup>, 2016**

Travel Dates: \_\_\_\_\_

**Expenses – All Receipts Required**

Expense Item and Detail	Expenses
<b>Registration Fees</b>	
<b>Airline or other Transportation</b>	
<b>Hotel- Maximum 2 Nights</b> <small>*NOTE: MSDA Master Account, this fee will be deducted from the \$800.00 stipend</small>	
<b>Ground Transportation</b>	
<i>Taxi- Home to Airport</i>	
<i>Taxi- Airport to Hotel</i>	
<i>Taxi- Hotel to Airport</i>	
<i>Taxi- Airport to Home</i>	
<b>Meals -Allowable</b>	
<i>Dinner - Monday, June 13th - \$36.00</i>	
<i>Dinner -Tuesday, June 14th - \$36.00</i>	
<b>Total</b>	

**Maximum amount reimbursable: \$800.00**

**Submit Travel Request with Receipts to:** [mfoley@medicaiddental.org](mailto:mfoley@medicaiddental.org)

**Mail to:**

Ms. Mary E. Foley  
2 Grove Street  
Sandwich, MA 02563

Signature \_\_\_\_\_ Date \_\_\_\_\_

**FORM MUST BE RECEIVED WITHIN 30 DAYS OF EVENT**