First Nations Health Authority
Travel Expense Claim

First Nations Health Authority
Health through wellness

Date:	Telephone:	
Payable To:	Meeting:	**Primary Care + Mental Health and Wellness Summit**
Must be made out to an ORGANIZATION		
Participant Name:	Mtg Location:	**Westin Bayshore** **1601 Bayshore Drive, Vancouver, BC V6G 2V4**
Address:	(Mtg Date) From:	**Wednesday, May 22, 2019**
Postal Code:	(Mtg Date) To:	**Friday, May 24, 2019**
Travel Start Date:	Travel Return Date:	

RECEIPTS ARE NOT NECESSARY TO RECEIVE REIMBURSEMENT FOR:

MEALS:

List dates claimed

Breakfast		Provided May 22, 23, 24	$15.75	# day(s)	=	$ -
Lunch		Provided May 22, 23, 24	$15.10	# day(s)	=	$ -
Dinner			$42.00	# day(s)	=	$ -
INCIDENTALS:		Per overnight stay only	$17.30	# nights(s)	=	$ -
PRIVATE ACCOMMODATION:			$50.00	# day(s)	=	$ -

MILEAGE:

From *(address)*:   To: *(address)*:

$ 0.51 X _____ = $ -

 # Round-trip Kms

ORIGINAL RECEIPTS ARE NECESSARY TO RECEIVE REIMBURSEMENT FOR:

** Please include name even if not claiming   * Please include return fare

ACCOMMODATIONS: Commercial: (room, taxes and parking only)

Was this billed directly to the FNHA: ☐ Yes ☐ No

** Hotel Name: lightly rate: $ _____ X _____ # of day(s) = $ -

TRAVEL:

Airfare: MUST INCLUDE BOARDING PASS, ITINERARY AND INVOICE

** Airline Name: _____ $ _____

From: _____ To: _____

Other:

Parking	Daily rate:	X		# of day(s)	=	$ -
Taxi	From:	to				$
Airporter/Shuttle	From:	to				$
Ferry	From:	to				$
Ferry	From:	to				$
Others(Specify)						$

TOTAL AMOUNT CLAIMED $ _____

Submitted by:
(Please print)

Submit to:

First Nations Health Authority
Attn: Accounts Payable
501-100 Park Royal South
West Vancouver, BC V7T 1A2
Ph: 604-693-6500

For Office Use Only					
APPROVED BY:					
ACCOUNT CODES:	**63004**	**600100**	**99041**	**10115**	**000000**
	G/L Code	Cost Centre	Program	Project	Location