SOUTHWEST DISTRICT
MICHIGAN ASSOCIATION OF HEALTHCARE ADVOCATES

EXPENSE VOUCHER

VOUCHER NO. _____

PAY TO _____ _____
(Your name) (Office/Committee Chairman)

ADDRESS_____ _____
(Your address) (City) (Zip Code)

PHONE NO: _____

TYPE OF EXPENSE:	TELEPHONE	$_____
	POSTAGE	$_____
	MILEAGE	$_____
	SUPPLIES/MATERIALS	$_____
	COFFEE/ROLLS	$_____
	LUNCHES	$_____
	MEETING EXPENSE	$_____
	OTHER	$_____

Please attach all receipts and please sign your name on all receipts…..

TOTAL $_____

Amount of expenses (if any) to be donated to SWD $_____

_____ _____
(Date) (Your signature)

(To be filled out by SWD President)
Charge to account:

MEETINGS:

General _____	$_____
Auxiliary Leadership_____	$_____
Operating _____	$ _____
Other _____	$_____

_____ _____
(Date approved) (President's signature)

Revised 2006