

# REIMBURSEMENT FORM



Please make copies of this form for future use.

Your reimbursement request will be processed through our Payroll Department and will be paid in the order your payroll account is established (i.e. direct deposit or live check).

## HEALTHCARE PROFESSIONAL'S INFORMATION

Date: \_\_\_\_\_ Placement Specialist's Name \_\_\_\_\_  
Full Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Daytime Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

## HOSPITAL INFORMATION

Hospital Name: \_\_\_\_\_ City/State: \_\_\_\_\_

## MILEAGE REIMBURSEMENT

*You do not need to fill out a reimbursement form for mileage to and from an assignment as this will automatically be reimbursed in your first and last paychecks. Your first travel reimbursement will come with your first paycheck and your second travel reimbursement will arrive within two weeks upon assignment completion.*

## ADDITIONAL EXPENSES

**Copies of permanent license(s) and proof of payment are *required*.**

Licenses and/or Verifications State(s): \_\_\_\_\_ Amount(s): \$ \_\_\_\_\_  
Airfare: \$ \_\_\_\_\_ Shuttle/Taxi: \$ \_\_\_\_\_ Other: \$ \_\_\_\_\_

\_\_\_\_\_  
U.S. NURSING Senior Manager Signature

### ACCOUNTING USE ONLY

Period Coding Amount

Account Coding: \_\_\_\_\_

Account Coding: \_\_\_\_\_

Employee ID: \_\_\_\_\_

**THIS FORM MUST BE SUBMITTED NO LATER THAN 90 DAYS AFTER EXPENSE WAS INCURRED**