

**CUPE HEALTH CARE COUNCIL  
EXPENSE VOUCHER**

**DATE:** \_\_\_\_\_

**NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**SIN:** \_\_\_\_\_

**REASON FOR EXPENSE:** \_\_\_\_\_

**DATE(S):** \_\_\_\_\_

**PER DIEM EXPENSES:**

\_\_\_\_ # DAYS @ \$20.00 (IN DISTRICT) \_\_\_\_\_

\_\_\_\_ # DAYS @ \$35.00 (IN PROVINCE) \_\_\_\_\_

\_\_\_\_ # DAYS @ \$72.00 (OUT OF PROVINCE) \_\_\_\_\_

**CHILD CARE:**

\_\_\_\_ # DAYS @ \$25.00 (ATTACH RECEIPT) \_\_\_\_\_

**MILEAGE:**

FROM: \_\_\_\_\_ TO: \_\_\_\_\_ [ ] RETURN \_\_\_\_\_

\_\_\_\_\_ KMS @ \$0.3385/KM

**HOTEL:** (ATTACH RECEIPT) \_\_\_\_\_

**PARKING:** (ATTACH RECEIPT) \_\_\_\_\_

**TELEPHONE/FAX/INTERNET:** \_\_\_\_\_

**OTHER: (SPECIFY & ATTACH RECEIPT)** \_\_\_\_\_

**TOTAL PAYMENT** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**CHEQUE #** \_\_\_\_\_

**AUTHORIZED BY:** \_\_\_\_\_

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