New York State Women, Inc. Expense Reimbursement Request

Name _____ Date Submitted _____

Address _____

_____

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Date of Expense	Description	Budget Account							Total
	Total								

Submitted By: _____ Budgeted Amount _____

Amount Paid _____

Approved By: _____ In Kind Service _____

* Receipts must be attached
* Reimbursement cannot exceed total amount budgeted
without approval of the Executive Committee
In Kind Services need to be listed with the actual or approximate value of the service