NYS Women, Inc. Expense Reimbursement Request

Name ______________________________ Date Submitted ______________________________

Address ______________________________

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←---Expenses---→

Date of Expense	Description	Budget Account							Total

Submitted By: ______________________________

Approved By: ______________________________

*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

Budgeted Amount ______________________

Amount Paid ______________________

In-Kind Service ______________________

Check # ___________