EXPENSE REIMBURSEMENT FORM

 **NOTE:**

All of the following information is required for expensing reasonable and legitimate meals/entertainment (please note that entertainment is prohibited for meetings/events/activities in relation with HCPs/GO/ HCOs/Government Institutions):

1. Date
2. Name of guest/s (please note that for meetings/events/activities with HCPs/GO it is prohibited to facilitate,
arrange, or pay for guests)
3. Title of guest
4. Name of guest’s company
5. Type of expense, i.e. dinner, lunch, etc.
6. Location name
7. Location city
8. Business justification/purpose, i.e., topics discussed
9. Amounts – all itemized receipts must be attached.

*Note that applicable local, regional laws, regulations and industry best practices codes must be considered when interacting with HCPs/GO/HCO’s/Government Institutions.*

Employee First & Last Name:

Date:

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Employee Signature Date Print First & Last Name

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Manager Signature Date Print First & Last Name

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Finance Signature Date Print First & Last Name

Total Reimbursement Requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Item # | Date | Type of Expense | Amount | HCP/GO-related expense? Yes/No | Number of Company Attendees | Company Attendee Name | Company Attendee Job Title | Number of HCPs/GOs Attendees | HCPs/GOs First & Last Names,Titles, Hospital Name | Any other Attendees? Yes/No | If yes, indicate First & Last Name, Title, Institution/Company |
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| Item # | Date | Type of Expense | Amount | HCP/GO-related expense? Yes/No | Number of Company Attendees | Company Attendee Name | Company Attendee Job Title | Number of HCPs/GOs Attendees | HCPs/GOs First & Last Names,Titles, Hospital Name | Any other Attendees? Yes/No | If yes, indicate First & Last Name, Title, Institution/Company |
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