CANADIAN CHIROPRACTIC EXAMINING BOARD
CONSEIL CANADIEN DES EXAMENS CHIROPRATIQUES
Centre 70 ~ Suite 705, 7015 Macleod Trail SW
Calgary, AB T2H 2K6
403 230-5997 volunteers@cceb.ca

EXPENSE FORM

Name ______________________________

Address ______________________________
Street
____
City Prov Postal Code

Event ______________________________

All expense claims must be supported by ITEMIZED RECEIPTS and submitted within 60 days of the event. OTHER FORMS OF PROOF WILL NOT BE ACCEPTED AND THE EXPENSE WILL BE DECLINED.

Please print name and address clearly to ensure your cheque arrives at the correct address.

Date	Travel			Meals Breakfast $15 Lunch $20 Dinner $30	Hotel	Misc	Description	
	# of km	Total @ $0.55/km	Taxi, Parking					
Subtotals							**TOTAL**	

WE WILL NO LONGER BE ISSUING CHEQUES FOR EXPENSES CLAIMED. THE ONLY FORM OF PAYMENT WILL BE DIRECT DEPOSIT.

PLEASE DO NOT MAIL IN OR FAX YOUR EXPENSES. PLEASE SCAN EVERYTHING IN AND EMAIL TO VOLUNTEERS@CCEB.CA. YOU CAN ALSO TAKE PICTURES OF YOUR EXPENSES AND EMAIL THEM TO VOLUNTEERS@CCEB.CA .

EXPENSE REIMBUREMENT IS BY DIRECT DEPOSIT. YOU MUST ATTACH A COPY OF A VOID CHEQUE WITH YOUR EXPENSES.

PAYMENT WILL BE PROCESSED WITH IN 30 DAYS OF RECEIPT OF YOUR COMPLETED EXPENSE FORM AND ACCOMPANYING RECEIPTS.. THANK YOU

I certify that the above information is a true and accurate record of the expenses I incurred on behalf of the CCEB in the performance of my assigned duties.

Signature ____________________________________ Date ____________________

Office Use Only

Approved	**Notes**