

**THE COMMISSION ON DENTAL COMPETENCY ASSESSMENTS**

**Expense Reimbursement Request Form**



Name: \_\_\_\_\_  
 Affiliation: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Email: \_\_\_\_\_

What is the purpose of this reimbursement?

Exam: \_\_\_\_\_  
 (Indicate Site)

Meeting: \_\_\_\_\_  
 (Indicate Committee or Organization)

Dates \_\_\_\_\_  
 (Only Dates Attended)

Dates: \_\_\_\_\_  
 (Only Dates Attended)

Type \_\_\_\_\_  
 (Dental or Hygiene)

Purpose: \_\_\_\_\_  
 (Describe)

	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Total	Account
Record Dates of Expense									
Air (include receipt)									5030
Rental Car (include receipt)									5031
Rental Car Fuel (include receipt)									5031
Rail (include copy of ticket)									5030
Personal Auto - Total Miles Here →									
Calculated @ \$.58 per mile									5031
Taxi/van/bus/limo (include receipts)									5031
Parking (include receipts)									
Tolls									5031
Lodging (include hotel bill)									5020
Misc. expenses (include receipts/explanation)									
									<b>TOTAL DUE</b>

**YOU MUST SIGN/TYPE & DATE THIS FORM:**

**DATE**

**Submit to the CDCA for reimbursement by sending to [invoice@cdcaexams.org](mailto:invoice@cdcaexams.org) or by mailing to the CDCA at PO Box 34781, Bethesda, MD 20827. Please attach/include receipts.**

**THIS FORM MUST BE SUBMITTED TO THE CDCA WITHIN 30 DAYS OF YOUR TRAVEL**