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)

Dates _____ (Only Dates Attended)

Type _____ (Dental or Hygiene)

Meeting: _____ (Indicate Committee or Organization)

Dates: _____ (Only Dates Attended)

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 @ $.56 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)									
									TOTAL DUE

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

Submit to the CDCA for reimbursement by sending to 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

Questions? Contact the CDCA - Ms. Jean Parker at jparker@cdcaexams.org

Revised 1/4/2021