

RIVERSIDE METHODIST HOSPITAL  
Columbus, Ohio

**EXPENSES**

**PLEASE RETURN WITHIN 30 DAYS OF YOUR PRESENTATION**

**NAME:**

**CONFERENCE:**

Please submit within ten (10) working days of the date listed above. Allow 30 days for processing, distributing, and mailing the check

HONORARIUM	\$ _____
AIRFARE/MILEAGE	\$ _____
HOTEL	\$ _____
CAB FARE(S)	\$ _____
MEALS	\$ _____
TIPS	\$ _____
<b>TOTAL</b>	<b>\$ _____</b>

**NOTE:**

ATTACH ALL RECEIPTS TO VALIDATE EXPENDITURES.

RECEIPTS ARE REQUIRED FOR EXPENDITURES OVER \$25.00.

CHECKS WILL BE MAILED THROUGH U.S. MAIL TO PAYEE.