Canadian Chiropractic Examining Board
Conseil Canadien des Examens Chiropratiques
Suite 230 – 1209 59 Avenue SE
Calgary, Alberta T2H 2P6
Fax (403) 230-3321 • volunteers@cceb.ca

EXPENSE FORM

Name _____

Address _____
Street

_____
City Prov Postal Code

All expense claims must be supported by receipts and submitted within 60 days of the event

Event _____

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**	

I wish to receive my expense reimbursement by way of e-transfer. I acknowledge that a $2.00 administration fee will be retained by the CCEB. Please email my transfer to _____.

Please note the password for all e-transfers will be the name of the city in which you participated in the meeting/examination.

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**