COMOX STRATHCONA
REGIONAL HOSPITAL DISTRICT

Director Expense Claim Form

Advance ______ **Claim:** ______

Director's Name: ______________________

Address: ______________________

Date	Location and Description of Function	Expense Detail (Hotel, Ferry, Airfare, Meals)	Amount
		TOTAL (A)	

Pursuant to CSRHD Remuneration Bylaw #244

1. Commercial Accommodation — Actual Cost
2. Non-Commercial Accommodation — $35/night
3. Per Diem and Meal Allowance — $75/day

   Rate Breakdown

   Breakfast: $28.40 (6:00-9:00am)

   Lunch: $27.40 (11:30am-1:30pm)

   Dinner: $48.28 (4:30-7:30pm)

   Incidentals $17.30 (for trips more than 24 hours only)
4. All other expenses (with receipts) — Actual Cost

Carry Forward of Automobile Distance Expenses **(B+C)**	
Less Advance Received (if applicable)	
Net Claim	

"I hereby certify that the expenses and expenditures detailed on this claim qualify for reimbursement and were incurred by me as a result of Comox Strathcona Regional Hospital District business as detailed in the CSRHD Bylaw No. 244 and that I will not be reimbursed for them by any other party."

Director's Signature | **Date** | **Corporate Legislative Officer**

Approved for Payment	Account No.	Cost Center

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Automobile Distance Expenses
According to Schedule "B", CSRHD Bylaw No. 244

Date	From	To	Purpose of Travel	Distance on Paved (B)	Distance on Unpaved (C)
			Total Distance Traveled (in KM)		
			Rate per KM	**$0.72 / KM**	**$0.86 / KM**
			Total Distance Expense		
			Total Expenses (B + C) Carry forward to front page		