

REIMBURSEMENT FORM



Please make copies of this form for future use.

Your reimbursement request will be processed through our Payroll Department and will be paid in the order your payroll account is established (i.e. direct deposit or live check).

HEALTHCARE PROFESSIONAL'S INFORMATION

Date: _____ Placement Specialist's Name _____

Full Name: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone: (_____) _____ Cell Phone: (_____) _____

HOSPITAL INFORMATION

Hospital Name: _____ City/State: _____

MILEAGE REIMBURSEMENT

You do not need to fill out a reimbursement form for mileage to and from an assignment as this will automatically be reimbursed in your first and last paychecks. Your first travel reimbursement will come with your first paycheck and your second travel reimbursement will arrive within two weeks upon assignment completion.

ADDITIONAL EXPENSES

Copies of permanent license(s) and proof of payment are required.

Licenses and/or Verifications _____ State(s): _____ Amount(s): \$ _____

Airfare: \$ _____ Shuttle/Taxi: \$ _____ Other: \$ _____

FASTAFF Senior Manager Signature

ACCOUNTING USE ONLY

Period Coding Amount

Account Coding: _____

Account Coding: _____

Employee ID: _____

THIS FORM MUST BE SUBMITTED NO LATER THAN 90 DAYS AFTER EXPENSE WAS INCURRED