

2021-2022 TRAVIS COUNTY MEDICAL ALLIANCE AND FOUNDATION
Expense Reimbursement/Check Request/Deposit Form

Member Name _____ Date _____ Phone _____

Organization (check one): Foundation _____ Alliance _____ Budget Line: _____

Form with invoice/receipts/other back-up documents required. Submit to treasurer in person, by mail or email.

Treasurer – TCMA Foundation

Beth O’Farrell - bofarrell21@gmail.com

Treasurer-Elect – TCMA Alliance

Verlaine MacClements - verlainemacc@gmail.com

Expense Reimbursement & Check Request

Check Payable to: _____

Mail to the following address: _____

Detail as follows:

Description	Amount
_____	_____
_____	_____
_____	_____
_____	_____
Total amount of Reimbursement or Check	\$ _____

Deposit

Description: _____

Total Amount of Checks _____

Total Amount of Cash _____

DEPOSIT TOTAL \$ _____

Special Instructions: _____

* Reimbursements to members must be submitted within 30 DAYS of purchase.

* Checks issued must be cashed within 90 DAYS.

* Before mailing to the Treasurer, make a copy of completed form and attachments.

* Taxes CANNOT be reimbursed from the TCMA Foundation.

Treasurer Completes: **Date Paid/Deposited:** _____

Check No. (if appl): _____