HealthSource global staffing

Accounts Payable Use Only

V2 ID _____

Manager Approval _____

Please EMAIL this form within one week after arrival and completion of assignment: hsgexpensereimbursement@healthsourceglobal.com

Name _____ **ADP ID** _____ **Date** _____

Phone # _____ **Event ID** _____

Travel Reimbursement Form

Facility Name _____ **Facility City** _____ **Facility State** _____

As you travel, keep airline document for verification in the event of an IRS audit once form is submitted no revisions will be accepted. To ensure finely processing. this form must include your printed name, signature and date. You have 60 days from the end of your assignment to submit this form to request travel reimbursement to be considered for non-taxable reimbursement. Requests submitted beyond 60 days could be subject to taxation. Incomplete or incorrectly completed forms may delay processing of your reimbursement.

Please Note:-

The company pays mileage based on actual miles traveled upto the travel cap for the assignment as defined In your Healthcare Professionals Agreement for this assignment Mileage is verified wilh mapping software for the most direct route.

Please complete a seperate form for each type of travel

☐ **Arrival Travel (to Assignment)**

☐ **End Travel (to home or next assignment)**

***End travel must be to a permanent or tax home address on the file or reimbursement may be subject to taxation.**

Select the mode of Transportation

☐ **Commercial Airline, Please e-mail your flight Itinerary to hsgexpensereimbursement@healthsourceglobal.com**

☐ **Automobile (Please complete the mileage information below)**

Beginning Odometer Reading _____

Ending Odometer Reading _____

Total Miles _____ ****True Odometer readings and/or flight documentation is required for reimbursement**

For Flights (Please provide Baggage information below)

Checked-in Baggage at Arrival of the Assignment _____

Checked-in Baggage at completion of the assignment _____

Other Expenses

Type _____

Amount _____

Dates of travel to or from the Facility _____ **Through** _____

Departure City _____ **Departure State** _____

Arrival City _____ **Arrival State** _____

HEALTHCARE PROFESSIONAL STATEMENT: I acknowledge that based on the company's use of an IRS-accountable plan for travel reimbursement. My reimbursement may be subject to taxation. Under penalty of perjury. I certify that the claim for travel reimbursement I am ma king is an accurate representation of the miles i traveled, or flight(s) i took to or from the assignment.

By typing my name below I attest that i am the person identified in this document, the information i have supplied is accurat e, and i authorize the investigative consumer report.

Signature (First and Last name) _____