



**CAPE COD  
HOSPITAL**

Auxiliary –  
Orleans Branch

### Reimbursement Form

**Board Members and Committee Chairs: Please PRINT OUT this form and use it when you need to be reimbursed for expenses. All requests for reimbursement should have receipts attached.**

Committee or Board Name \_\_\_\_\_

Event/Purpose \_\_\_\_\_

Itemized Expenses (please attach all receipts)

_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
	Total: \$ _____

Signed \_\_\_\_\_

Print Your Name \_\_\_\_\_

Date \_\_\_\_\_

**Please submit all expenses to the Treasurer as promptly as possible. Thank you.**