## P.O. Box 7044 Rockford, IL 61125 Phone: 815-399-4300

## **Professional Expense**Reimbursement

NAME: REIMBURSEMENT PERIOD:				
PARISH/CCHS/AGENCY: CITY:				
Comments:	Please indicate the full date and a brief description of ministry ${\sf p}$ See example below.	ry purpose, and attach receipts.		
Professional Expense Summary: (attach receipt for each item				
DATE	Description - Category	Amount	Receipt	
10/1/2016	Example: US Cleaners – dry cleaning	35.00	√	
	TOTAL Professional Expense	s		
	e total from separate mileage log(s) miles x \$0.585 Si reimbursement rate (0.585 effective January 1, 2022)  Ofessional Expense Reimbursement Requested:  Limited to \$9,600 annually per fiscal year	= \$		
Signature:	Ε	Date:		

#### Catholic Diocese of Rockford





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NAM	E:	REIMBURSEMENT PERIOD:	REIMBURSEMENT PERIOD:		
PARISH/CCHS/AGENCY:		GENCY: CITY:	CITY:		
Comments: Please indicate the full date and a brief description of ministry purpose. See example be (Trips to hospital, nursing home, travel for meetings or conferences.)					
	DATE	DESCRIPTION OF TRAVEL INCLUDING PURPOSE & LOCATION	MILEAGE		
	10/1/2016	Example: St. Anthony Hospital – sick calls	10		
-					
-					
-					
-					
-					

Total mileage to be carried over to Professional Expense Reimbursement form:

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### **Table Expense Reimbursement**

DATE	Grocery Store / Restaurant	Amount	Receipt
10/1/2016	Example: Whole Foods - groceries		√
	TOTAL Table Expense (Split into categories below)		
OTAL by cat	tegory: RECEIPTS MUST BE ATTACHED FOR ALL ITEMS.		
Table Expense –		\$	
•	Personal meals at restaurants (not ministry-related)	Ψ <u> </u>	<del>-</del> *

<sup>\*</sup> Note: Personal meals at restaurants are reimbursable, but according to IRS rules, are taxable and will be added to W-2 wages.