ACHIEVE BEYOND
Pediatric Therapy & Autism Services
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www.achievebeyondusa.com

Therapist Reimbursement Form

Name: _____
Month: _____
Office: _____

Expenses *			Amount
Transportation Allowance:			
1. Car Allowance			$ -
2. Mileage Reimbursement**	Total Miles:		
	Rate:	0.54	
Cell Phone:			
			0
Tuition Reimbursement:			
Other Expenses:			
		Total	

*** Please attach all ORIGINAL receipts. Incomplete Reimbursement forms will not be processed**

**** Mileage Report needs to be completed & attached**

Today's Date _____

Employee's signature _____

Supervisor's Name _____

Supervisor's Signature _____