MARION EYE CENTER
& Optical

DOCTOR REIMBURSEMENT

DR. NAME____

TOTAL AMOUNT TO BE REIMBURSED $_______________ . _________

PLEASE FILL IN AMOUNTS FOR EACH EXPENSE (All receipts must be included):

CME	$________________ . __________
MEALS	$________________ . __________
HOTELS	$________________ . __________
TRAVEL	$________________ . __________
MEMBERSHIP RENEWAL	$________________ . __________
OTHER (PLEASE EXPLAIN)	$________________ . __________
OTHER (PLEASE EXPLAIN)	$________________ . __________

COMMENTS:____

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DOCTOR SIGNATURE **DATE**