DATE OF CTP INSPECTION ________________ DATE OF CBB INSPECTION ________________

TRAVEL AND EXPENSE REPORT

FORM MUST BE FILLED OUT COMPLETELY. *ORIGINAL* RECEIPTS *MUST* BE SUBMITTED. EXPENSES FROM LOST, SCANNED, OR COPIED RECEIPTS CANNOT BE REIMBURSED.

INSPECTOR NAME: ________________________________

INSPECTOR PROGRAM/BANK: ________________________________

ADDRESS: ________________________________

CITY/PROVINCE: ________________ STATE: ________

ZIP CODE ________ COUNTRY: ________________

PROGRAM/BANK INSPECTED: ________________________________

CITY/PROVINCE: ________________________________

STATE: ________ COUNTRY: ________________

REPORT TURNED IN: ☐ YES ☐ NO

Click to Select Date for each column:					Total Expenses
Food - Breakfast					
Food - Lunch					
Food - Dinner					
Airline Tickets (If applicable)					
Lodging					
Taxi/Shuttle					
Parking					
Car Rental (must receive prior authorization)					
Gratuities					
Miscellaneous					
TOTAL					

INSTRUCTIONS

1. Print your name, name of institution, and address where your check should be sent.
2. Please include the facility you inspected and the date of the inspection.
3. Expenses must be itemized on a daily basis. Please attach all original receipts. (Faxes, copies, scanned, or lost receipts are not reimbursable.)
4. If meal receipts include expenses for other team members, please indicate the names of all individuals in attendance.
5. Unnecessary or unreimbursable expenses will not be refunded (Travel Guidelines and Expense Reimbursement Policy, 1.1.004).
6. If airline expenses are paid directly by FACT, do not include these expenses. Include only airline expenses paid by you.
7. Car rentals must receive prior authorization by the FACT office.
8. Expenses will not be reimbursed prior to receipt of your completed final inspection report.
9. Send completed form and receipts to: FACT, 986065 Nebraska Medical Center, Omaha, NE 68198-6065

Reviewed by________ Date______________ Approved by________ Date______________