

**EXPENSE REPORT**

Allied

NAME: \_\_\_\_\_

**ProCare One Nurses**

DATE: \_\_\_\_\_



ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

SS# \_\_\_\_\_

**Note:**

Please allow 2 weeks to be reimbursed.

**\*\*\*\*ORIGINAL RECEIPTS AND SIGNATURE REQUIRED-INCOMPLETE REPORTS WILL BE DENIED\*\*\*\***

**Note: Original Receipts cannot be returned due to Company Policy**

|    | Date | Account Code | Description/Name | Accommodations | Transportation | meals*** | Phone*** | Entertainment*** | Other | Total          |
|----|------|--------------|------------------|----------------|----------------|----------|----------|------------------|-------|----------------|
| 1  |      |              |                  |                |                |          |          |                  |       | \$             |
| 2  |      |              |                  |                |                |          |          |                  |       | \$             |
| 3  |      |              |                  |                |                |          |          |                  |       | \$             |
| 4  |      |              |                  |                |                |          |          |                  |       | \$             |
| 5  |      |              |                  |                |                |          |          |                  |       | \$             |
| 6  |      |              |                  |                |                |          |          |                  |       | \$             |
| 7  |      |              |                  |                |                |          |          |                  |       | \$             |
| 8  |      |              |                  |                |                |          |          |                  |       | \$             |
| 9  |      |              |                  |                |                |          |          |                  |       | \$             |
| 10 |      |              |                  |                |                |          |          |                  |       | \$             |
| 11 |      |              |                  |                |                |          |          |                  |       | \$             |
| 12 |      |              |                  |                |                |          |          |                  |       | \$             |
|    |      |              |                  |                |                |          |          |                  |       | Subtotal       |
|    |      |              |                  |                |                |          |          |                  |       | Minus Advances |
|    |      |              |                  |                |                |          |          |                  |       | TOTAL          |

DATE: \_\_\_\_\_

SUBMITTED BY (EMPLOYEE) \_\_\_\_\_

Signature

DATE: \_\_\_\_\_

SUPERVISOR APPROVAL: \_\_\_\_\_

Signature

Assignment Hospital \_\_\_\_\_

|                     |  |                |    |
|---------------------|--|----------------|----|
| Begin Odometer Read |  | to Destination |    |
| End Odometer Read   |  | from           |    |
| Total Miles         |  | x \$ 0.375=    | \$ |

Assignment Dates: \_\_\_\_\_

- ◆ Original reports and receipts must be mailed to:  
On Assignment Healthcare Staffing, 8150 Corporate Park Dr., Suite 300 Cincinnati, OH 45242. Attn: Allied
- ◆ Only Documents accepted by fax# 1-866-741-0884 are:  
Expense reports for mileage or  
The front and back of a cancelled check for licensure reimbursement, instead of a receipt.

EXPENSE REPORT

**ProCare One Nurses**



NAME: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 PHONE: \_\_\_\_\_

DATE: \_\_\_\_\_

**Note:**  
*Please allow two weeks to be reimbursed.*

**ORIGINAL RECEIPTS AND SIGNATURE REQUIRED BY THE PAYROLL DEPARTMENT TO ISSUE EXPENSE REIMBURSEMENT CHECKS. REPORTS NOT ACCOMPANIED WITH THE ORIGINAL MAY BE DENIED.**

|    | Date | Description | State Licensure | Car Rental | Airline | Hotel | Misc | Other | Total          |
|----|------|-------------|-----------------|------------|---------|-------|------|-------|----------------|
| 1  |      |             |                 |            |         |       |      |       | \$             |
| 2  |      |             |                 |            |         |       |      |       | \$             |
| 3  |      |             |                 |            |         |       |      |       | \$             |
| 4  |      |             |                 |            |         |       |      |       | \$             |
| 5  |      |             |                 |            |         |       |      |       | \$             |
| 6  |      |             |                 |            |         |       |      |       | \$             |
| 7  |      |             |                 |            |         |       |      |       | \$             |
| 8  |      |             |                 |            |         |       |      |       | \$             |
| 9  |      |             |                 |            |         |       |      |       | \$             |
| 10 |      |             |                 |            |         |       |      |       | \$             |
| 11 |      |             |                 |            |         |       |      |       | \$             |
| 12 |      |             |                 |            |         |       |      |       | \$             |
|    |      |             |                 |            |         |       |      |       | Subtotal       |
|    |      |             |                 |            |         |       |      |       | Minus Advances |
|    |      |             |                 |            |         |       |      |       | Total          |

SUBMITTED BY (EMPLOYEE) \_\_\_\_\_  
 Signature

DATE: \_\_\_\_\_

SUPERVISOR APPROVAL: \_\_\_\_\_  
 Signature

DATE: \_\_\_\_\_

Assignment Hospital \_\_\_\_\_

|                     |  |                |    |
|---------------------|--|----------------|----|
| Begin Odometer Read |  | to Destination |    |
| End Odometer Read   |  | from           |    |
| Total Miles         |  | x \$ 0.34=     | \$ |

Assignment Dates: \_\_\_\_\_

- ◆ Original reports and receipts must be mailed to:  
 ProCare One Nurses, Attn: Payroll - 4041 MacArthur Blvd, Suite 150 Newport Beach, CA 92660
- ◆ Only Documents accepted by fax# 1-800-838-4747 are: Expense Reports for Mileage and the front and back of a cancelled check for licensure reimbursement, instead of a receipt.