Ansar Shrine Center
630 S. 6th St.
Springfield, IL. 62701

Transportation Voucher to Shriners Hospital for Children

Date___________

Date of appointment________________________(Please attach proof of appointment)

Hospital____________________________________

Name of patient______________________________

Parent that transported patient:

Name____

Mileage___________ x .25 cents per mile_______________________________________

Food_______________________________________

(Please enclose all meal tickets. Maximum per day is $ 15.00 per day for parent that transported, plus $15.00 per day for patient)

Hotel_______________________________________

(MUST BE APPROVED PRIOR TO APPOINTMENT)

Total reimbursement________________________________

Submitted by_____________________________________

Make check payable to :______________________________

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