Ansar Shrine Center

630 South 6th Street – Springfield, IL 62701

Transportation Voucher to Shriners Hospital for Children

Date_____

Date of appointment_____ (please attach proof of appointment)

Name of Patient _____ Address_____

Hospital_____

Parent that transported patient:

Name_____

Mileage_____ X .725 cents per mile $_____

Food $_____

(Please enclose all *itemized* meal receipts. Maximum is $25.00 per day for parent who transported, plus $25.00 per day for patient.)

Hotel_____ (Must be approved prior to appointment)

***TOTAL REIMBURSEMENT $_____**

Submitted by _____

Make check payable to:

_____

(Name)

_____

(Address, City, State, Zip) (Phone)

Email Address: _____