

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)

Hospital _____

Name of patient _____

Parent that transported patient:

Name _____

Mileage _____ x .40 cents per mile _____

Food _____

(Please enclose all meal receipts. Maximum per day is \$20.00 per day for parent who transported, plus \$20.00 per day for patient)

Hotel _____

(Must be approved prior to appointment)

Total reimbursement _____

Submitted by _____

Make check payable to: _____
