COMOX STRATHCONA
REGIONAL HOSPITAL DISTRICT

Director Expense Claim Form

Advance ☐ **Claim:** ☐

Director's Name: _____

Address: _____

Date	Location and Description of Function	Expense Detail (Hotel, Ferry, Airfare, Meals)	Amount
		TOTAL (A)	$ 0.00

Pursuant to CSRHD Remuneration Bylaw #244

1. Commercial Accommodation — Actual Cost
2. Non-Commercial Accommodation — $35/night
3. Per Diem and Meal Allowance — $75/day

   Rate Breakdown
   - Breakfast: $15 (6:00-9:00am)
   - Lunch: $20 (11:30am-1:30pm)
   - Dinner: $25 (4:30-7:30pm)
   - Incidentals: $15 (for trips more than 24 hours only)

4. All other expenses (with receipts) — Actual Cost

Carry Forward of Automobile Distance Expenses **(B+C)**	$ 0.00
Less Advance Received (if applicable)	
Net Claim	$ 0.00

"I hereby certify that the expenses and expenditures detailed on this claim qualify for reimbursement and were incurred by me as a result of Comox Strathcona Regional Hospital District business as detailed in the CSRHD Bylaw No. 244 and that I will not be reimbursed for them by any other party."

Director's Signature _____ **Date** _____ **Corporate Legislative Officer** _____

Approved for Payment	Account No.	Cost Center

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Automobile Distance Expenses
According to Schedule "B", CSRHD Bylaw No. 244

Date	From	To	Purpose of Travel	Distance on Paved (B)	Distance on Unpaved (C)

Total Distance Traveled (in KM)	0	0
Rate per KM	**$0.72 / KM**	**$0.86 / KM**
Total Distance Expense	$ 0.00	$ 0.00
Total Expenses (B + C) Carry forward to front page	$ 0.00	