

**2022-2023 TRAVIS COUNTY MEDICAL ALLIANCE AND FOUNDATION  
Expense Reimbursement/Check Request/Deposit Form**

Member Name \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_

Organization (check one): Foundation \_\_\_\_\_ Alliance \_\_\_\_\_ Budget Line: \_\_\_\_\_

*Form with invoice/receipts/other back-up documents required. Submit to treasurer in person, by mail or email.*

**Treasurer – TCMA Foundation**

Verlaine MacClements  
vp\_treasurer@tcmalliance.org

**Treasurer-Elect – TCMA Alliance**

Alison Queralt  
alisonqueralt@gmail.com

**Expense Reimbursement & Check Request**

Check Payable to: \_\_\_\_\_

Mail to the following address: \_\_\_\_\_

\_\_\_\_\_

Detail as follows:

Description	Amount
_____	_____
_____	_____
_____	_____
_____	_____
Total amount of Reimbursement or Check	\$ _____

**Deposit**

Description: \_\_\_\_\_

Total Amount of Checks \_\_\_\_\_

Total Amount of Cash \_\_\_\_\_

DEPOSIT TOTAL \$ \_\_\_\_\_

**Special Instructions:** \_\_\_\_\_

- \* Reimbursements to members must be submitted within 30 DAYS of purchase.
- \* Checks issued must be cashed within 90 DAYS.
- \* Before mailing to the Treasurer, make a copy of completed form and attachments.
- \* Taxes CANNOT be reimbursed from the TCMA Foundation.

**Treasurer Completes:**      **Date Paid/Deposited:** \_\_\_\_\_      **Check No. (if appl):** \_\_\_\_\_