

Ref No. _____

**AMERICAN INTERNATIONAL HEALTH ALLIANCE
TRAVEL VOUCHER**

(Name) _____ Mailing Address for Payment: _____ _____ _____	(Date of Travel) _____ (Trip #) _____ (Destination) _____
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Section I	Expenditures: Original receipts should be marked to coincide with posted line number.
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No.	Date	Type of Expense	Local Currency Amount	Exchange Rate	U.S. Dollar Amount
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					

TOTAL CLAIMED \$ \$0.00

III. SUMMARY OF EXPENSES CLAIMED	IV. FOR AIHA USE ONLY
Total Expenses (from above) \$ <u>0.00</u>	Approved for Payment
Plus Monies Transferred to Other AIHA Personnel or Contractor \$ <u>0.00</u>	Per Diem \$ _____
Less Travel Advance from AIHA(AMEX) \$ _____	Other \$ _____
Less Monies Received from Other AIHA Employees \$ <u>0.00</u>	Total \$ <u>0.00</u>
TOTAL DUE TO TRAVELER (DUE TO AIHA) \$ <u>0.00</u>	Less: Travel Advance/AMEX \$ _____
	Approved for Payment \$ <u>0.00</u>
SIGNATURE: _____	DATE: _____