



**Travel** Please include original receipts and proof of medical appointment such as parking or hospital admission/discharge papers or office visit paperwork

Date of Travel	Expense: Gas/Hotel/Parking	Amount	Destination and Purpose
_____	_____		_____
_____	_____		_____
_____	_____		_____
_____	_____		_____
_____	_____		_____
_____	_____		_____
<b>Total</b>			\$ _____

**Other Requests:**

Please describe any additional items you are submitting for reimbursement. Anything not listed in eligible expenses must be a medical expense and **pre-approved**.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Mail this form, your supporting documents & receipts to:**

Georgia Transplant Foundation  
TFP  
2201 Macy Dr.  
Roswell, GA 30076

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Date Processed: \_\_\_\_\_ Reimbursement Amount: \_\_\_\_\_