FONDATION
MEDIC

EXPENSE CLAIM FORM FOR MEDIC MEETINGS

Meeting (type, place, date) ______________________

Participant Dr./Mrs.Mr. ______________________

Address ______________________

____

Bank/City ______________________

Account Number ______________________

IBAN Number ______________________

SWIFT ______________________

Clearing No. ______________________

Transportation – air fare ______________________

Train ______________________

Taxi ______________________

Car ______________________

Hotel ______________________

Miscellaneous ______________________

TOTAL ______________________

Please fill in this form and attach original receipts/tickets

Send to:

Mrs Ghislaine Perriard
Institut de Pathologie
Bugnon 25
CH-1011 Lausanne
ghislaine.perriard@chuv.ch

Signature ______________________