



**Canadian Chiropractic Examining Board
Conseil Canadien des Examens Chiropratiques**

Suite 230 – 1209 59 Avenue SE
Calgary, Alberta T2H 2P6
Fax (403) 230-3321 • volunteers@cceb.ca

EXPENSE FORM

Name _____

Address _____
Street

City _____ Prov _____ Postal Code _____

**All expense claims
must be supported by
receipts and submitted
within 60 days of the event**

Event _____

Please print name and address clearly to ensure your cheque arrives at the correct address.

Date	Travel			Meals Breakfast \$15 Lunch \$20 Dinner \$30	Hotel	Misc	Description
	# of km	Total @ \$0.55/km	Taxi, Parking				
Subtotals							TOTAL

I certify that the above information is a true and accurate record of the expenses I incurred on behalf of the CCEB in the performance of my assigned duties.

Signature _____ Date _____

Office Use Only

Approved	Notes
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