**OREGON PUBLIC HEALTH ASSOCIATION**

**REQUEST FOR PAYMENT/REIMBURSEMENT**

(To be used by Sections, Board members, Committee members)

**Date: 5/27/22**

**Name of Requestor: Connie Guist**

**Amount Requested: $80.00**

**List Expenses & Purpose:**

*(Please attach receipts/invoice/documentation. For events where food is provided, please attach list of attendees and a brief description of the event.)*

*In the case of a lost receipt, please provide the amount, purpose, and details of the purchase on this form.*

Purchased 8 $10 Starbucks gift cards and sent electronically to participants attending the OPHA Nursing Section Leadership Luncheon on 5/12/22.

Receipts are attached to the same email sent with this Request for Reimbursement form.

**Account to be charged: Nursing Section**

**Authorization Signature: Connie Guist, Nursing Section Treasurer**

**Name check made out to: Connie Guist**

**Mailing address to send check: 1300 NE 16th Ave. #511**

**Portland, OR 97232**

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

# EXECUTIVE DIRECTOR AND TREASURER USE ONLY

Check #

Account/Fund/Class

Treasurer or ED signature & date:

2/2/2017