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MARITIME RESIDENT DOCTORS

Healthy Resident Program
Expense Claim Form

Name (Wellness Leader): _____ ***Signature:*** _____

Residency Program: _____

Wellness Initiative: _____ ***Claim Date:*** _____

Email: _____

FOR FIRST TIME SUBMISSION ONLY

AUTHORIZATION AGREEMENT: I hereby authorize Maritime Resident Doctors to initiate payment deposits for my expense claims to be deposited into my account at the financial institution named below. I also authorize Maritime Resident Doctors to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold Maritime Resident Doctors responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until Maritime Resident Doctors receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the financial department.

Name of Financial Institution: _____

Branch/Transit # (5 digits): _____ ***Financial Institution # (3 digits):*** _____

Account # (minimum 7 digits): _____

Authorized Signature: _____

Date: _____

Expense Description:	Cost:
Wellness Initiatives:	
Healthy Snacks/Coffee:	
Sports Event/Team:	
Lounge Upgrades:	
Miscellaneous (explain):	

TOTAL EXPENSES :

All original receipts are required for reimbursement. For questions, please contact Leanne@mardocs.ca

For Mardocs office use only:

Date Reimbursed:	Cheque #:	Amount:	Staff initials: