Public Agency Risk Management Association
2024 Reimbursement Expense Form

Date:_____

Claimant Name: _____

Payee Address: _____

_____

Meeting or Event: _____

Date (s): _____

Purpose:
☐ Reimbursement for Travel Expenses
☐ Purchase of Supplies on behalf of PARMA
☐ Other _____

MEALS / MISCELLANEOUS

Per Diem Maximum Amount	Breakfast **$15.00**	Lunch **$20.00**	Dinner **$40.00**	*Incidental Expenses **$25.00**	TOTALS
Date:					
Date:					
Date:					
Date:					
Date:					

*for each night of hotel stay on PARMA business. No receipts required if $25 or less Sub-Total _____

TRAVEL

	Auto Mileage	Auto Rental / Taxi	Airplane/Train Fare	Parking
	# miles x 67 cents per mile =		From: _____ To: _____	
Date:				
Date:				
Date:				

Sub-Total _____

OTHER EXPENSES:

Please List Category & Amount(s)
Date:
Date:
Date:

TOTALS: _____

Claimant's Signature: _____

Please e-mail, mail or fax completed form & receipts to:
PARMA
One Capitol Mall, Suite 800
Sacramento, CA 95814
Fax: 916.444.7462 l e-mail: gpeterson@amgroup.us

Approved by:_____Date Paid:_____Amount: $_____ Check# _____