



**Public Agency Risk Management Association
2025 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 .70 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 | e-mail: gpeterson@amgroup.us**

Approved by: _____ Date Paid: _____ Amount: \$ _____ Check# _____