

AMERICAN LEGION AUXILIARY

Department of Illinois

**EXPENSE ACCOUNT FOR HOSPITAL REPRESENTATIVES,
SERVICE TO VETERANS REPS AND DEPUTIES**

This form must be filled out and mailed monthly to the Department of Illinois, American Legion Auxiliary,
P.O. Box 1426, Bloomington, IL 61702-1426.

DATE _____ ***EXPENSES FOR THE MONTH OF** _____

NAME OF REP/DIRECTOR/DEPUTY _____

NAME OF FACILITY _____

MILEAGE ROUND TRIP _____ **MILES** **NUMBER OF TRIPS THIS MONTH** _____

DATE OF TRIPS _____

POSTAGE _____

TELEPHONE CALLS _____

NOTES:

TOTAL OF EXPENSES \$ _____

***Expense shall be allowed for one trip per
week to facility unless otherwise approved.**

Submitted by (Representative or Deputy)

**Service to Veterans/Hospital Service
Department Chairman Approval**

Date _____

Finance Chairman Approval

Date _____