SAN JUAN COUNTY
Public Hospital District No. 1

Miscellaneous Staff Expense Reimbursement Form

Staff Name: _____ Date: _____

Date	Vendor	Description	Total Amount	BARS Code
		Total:	$0.00	

I hold the position of _____. I hereby submit an itemized account totaling $0.00.

I affirm and declare that all expenses listed above are accurate, legitimate, and truthful; that each expense was properly authorized; and that all costs were actually incurred and were necessary in the performance of official Hospital District business.

Signature of Claimant _____ Approved by _____

Revised 12/12/2025