



MSDA
 MEDICAID / SCHIP
 DENTAL ASSOCIATION

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Travel Reimbursement Form * 2010 MSDA Medicaid Symposium

Name _____ Phone _____
 Agency _____ SS# _____
 Title: _____ Email _____
 Address _____ City/State/Zip _____

Please check all that apply:

- Meeting/Conference: 2010 MSDA Medicaid Symposium April 24-25th
 2010 National Oral Health Conference; April 26th
 2010 ASTDD National Oral Health Leadership Institute April 24th

Location: St. Louis, Missouri
 Symposium/Conference Dates: April 24-25th, 2010 and April 26th-28th

Arrival Date: _____ Departure Date: _____

Number of nights/lodging: _____ (Maximum 3 Member/4 Board Member)

MSDA Member MSDA Associate Member MSDA Board Member

ACTUAL Expenses/Original Receipts Attached

| | Check Box or Enter Estimated Total Dollar Amount |
|--|--|
| Registration | <input type="checkbox"/> Saturday \$35.00 <input type="checkbox"/> Sunday \$ 100.00 <input type="checkbox"/> Medicaid/SCHIP Track \$270.00 (Sat/Sun/Mon) |
| Transportation/Airfare & Ground | \$0.00 |
| Hotel \$111.00/night +17% tax | \$0.00 |
| Meals | \$0.00 |
| Total | \$00.00 (Not to exceed \$900.00/Member & \$1,100.00/Board Member) |

 MSDA Member Signature

 Date