



Council on Volunteer Services
Georgia Health Care

**Board of Management
Expense Report**

Attach ALL Receipts

Name _____ Date _____

Address _____ City & Zip _____

For Period Beginning _____ Ending _____

| Item | Reason | Amount |
|--------------|--------|--------|
| | | |
| | | |
| | | |
| | | |
| | | |
| Total | | \$ |

Signature _____ Scanned Copies & Receipts are acceptable.

SEND TO:
Brenda Foy
22 Terrace Ct. SE
Moultrie, GA 31788

Mileage Reimbursed at  \$.60/mile

Official Use Only

Date Received _____ Date Paid _____ Check # _____