MSHN
Mid-State Health Network

Substance Use Disorder (SUD)
Oversight Policy Advisory Board (OPB)

PER DIEM & TRAVEL EXPENSE VOUCHER

NAME: _____

MAILING ADDRESS: _____

PERIOD COVERED: FROM: _____ TO: _____

Day of Month	Description	Per Diem Amount	Mileage/Meals/Other

NOTE: Please attach meal receipts, hotel receipts, parking receipts, etc., in accordance with MSHN Travel Policy and MSHN Board Member Compensation Policy.

_____

MSHN SUD OPB Member Signature Date