Ansar Shrine Center

630 South 6th Street
Springfield, IL. 62701

Transportation Voucher to Shriners Hospital for Children

Date_____________

Date of appointment______________(Please attach proof of appointment)

Name of patient__________________

Parent that transported patient:

Name________________________

Mileage_____________________

Food____________________

(Please enclose all meal receipts. Maximum per day is $12.00 per day for parent who transported, plus $12.00 per day for patient)

Hotel_______________________

(Must be approved prior to appointment)

Total reimbursement_______________________

Submitted by_____________________________

Make check payable to:____________________________________

____

____