

# EXPENSE REIMBURSEMENT VOUCHER

*South Dakota District of the LCMS*

*3501 S Gateway Blvd, Sioux Falls, SD 57106-1557*

NAME _____	DATE SUBMITTED: _____, 2023
ADDRESS _____	PURPOSE OF EXPENSES: _____
CITY,STATE,ZIP _____	Account # _____

DATE	WHERE TO	WHAT	Miles @.655/mi	Meals	Motel	Supplies	Misc.	Total	Optional Donation

*Please submit statement with receipts to District Business Office.*

Signature _____	GRAND TOTAL \$ _____
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