



National Down Syndrome Congress' Annual Convention Reimbursement Application

Before applying, please refer to the "FCDSN Reimbursement Program Policies"

Member Name: _____ Date: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____ Phone: _____

Reimbursement is requested for the following:

Conference Title: _____
Conference Location: _____
Conference Dates: _____
Registration fee(s): \$ _____

Transportation (Airfare) \$ _____

Other Costs: _____

Mileage

(for private vehicles only)

No Miles (roundtrip)	Standard Mileage Rate per mile	Total
	\$	\$

Hotel/Lodging

No. of Nights	Standard Rate per night or actual (whichever is less)	Total
	\$	\$

Total reimbursement requested: _____

As required, attach the following: 200-250 word publication to share and Original Receipts

Signature of person completing form: _____ Date: _____

Original receipts are required for disbursement of funds. Keep a copy of your receipts and this submission for your own records. Submit the completed & signed application with original receipts to:

**FCDSN Reimbursement Programs
2117 Buffalo Road #132
Rochester NY 14624**

Do Not Write in Box Below:

Member in good standing? Yes No Verified by: _____

Application: Approved Denied/Reason: _____

Reply Mailed On: _____ Check # _____ Amount: \$ _____

Entered: Date: _____



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