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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