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| **Expense Claim Form** |  |
|  |
| Company Name:  |  |  |  |
| Employee Name:  |  |  Employee ID: |  |
| Department:  |  |  Expense Period: |  |
|  |
| Itemized Expenses |  |
| Date | Description | Category | Amount Paid |
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|  | Subtotal: |  |
| Employee Signature: |  | Date: |  | Advance Payment: |  |
|  |  |  |  | Total Reimbursement: |  |