Name ____

Medicine Residency Program

Expense Summary Form
Belltown Continuity Clinic Parking

Date	Amount*	Date	Amount*
________	______	________	______
________	______	________	______
________	______	________	______
________	______	________	______
________	______	________	______
________	______	________	______
________	______	________	______

Total____________________

*Not to exceed $10.00 per day per week.

I certify that I incurred the above parking expenses while attending my continuity clinic at the Belltown clinic.

____

Signature Date

Return to:
Nina Hanlon
Medicine Residency Program
Box 356421