Name ___________________________________

Medicine Residency Program

Expense Summary Form

Pioneer Square 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 Pioneer Square clinic.

____

Signature Date

Return to:
Nina Hanlon
Medicine Residency Program
Box 356421
Seattle, WA 98195