

Board and Executive Expense Report

Name Dr. Vanessa MacLean
Title Zone Medical Director, South Zone
Location Lethbridge
 Expenses submitted during the month of December 2012

Travel (1)										
Date	Source Document	Purpose	Airfare	Meals	Accommodation	Other Travel	Total Travel	Professional Development (2)	Working Sessions Hosting and Hospitality (3)	Other (4)
November to December 2012	Expense Claim	Various meetings				1,047	1,047			
November 2012	P-Card	Credit for incorrect charge			(13)		(13)			
Total			\$ -	\$ -	\$ (13)	\$ 1,047	\$ 1,034	\$ -	\$ -	\$ -

Total for the Month \$ 1,034

Maximum meal expense claimed in the month \$ -
 Maximum daily hotel rate claimed in the month \$ -
 Non economy air travel in the month \$ -

1) Travel expenses

Includes local and out of province/country travel expenses. Other travel includes items such as taxis, parking mileage, car rental and other expenses related to travel.

2) Professional Development

Includes conference, seminar and course registration fees and material

3) Hosting and Hospitality expenses

Hospitality and Hosting expenses may be incurred to advance AHS' mission, vision and values. For example, may include working lunches with staff and prospective employees meetings with government officials, dignitaries, public interest groups, donors other public or private organizations.

4) Other

Other expenses include expenses incurred in the normal course of business that are required for work purposes. May include small item technology purchases, books, etc.

Car allowance and any other employment benefits reported in the annual financial statements are excluded from this report

TRAVEL, HOSPITALITY & WORKING SESSION EXPENSE CLAIM

AHS - Edmonton
 Accounts Payable
JAN 14 2013
RECEIVED

MB
 10 301

SECTION A: EMPLOYEE DETAILS (for AHS Staff ONLY)

• Enter employee # (old) and Employee # (E-People) if your payroll has migrated to the New E-People payroll system
 • Indicate N/A in the Employee # (E-People) if your payroll has not migrated to the New E-People payroll system
 • If you are a new employee and your payroll is E-People you will only have an Employee # (E-People)

Expense Date From: 23-Nov-12 To 31-Dec-12
 Travel Period from: Nov 23/12 To 31-Dec-12 (if applicable)
 Out-of-Province Travel

Name: Dr. Vanesen Medcun Position (Title): South Zone Medical Director
 Location: Chinook Regional Hospital Dept: Medical Affairs DOFA Level: 3a (if applicable) Union: Business Phone #: Ext:
 Employee # (E-People): Employee # (REQUIRED # prior to E-People migration):

SECTION E: FINANCE CODING & TOTAL CLAIM

CAPITAL PROJECT CODING ONLY → Project Number _____ Project Task Number _____
 Expenditure Organization _____ Expenditure Type _____

Total - Section B: Travel - Pg 2					Total - Section C&D: Other & Foreign Expenses - Pg 3					TOTAL REIMBURSEMENT	
Pg	Bal Unit	Location	Functional Centre (FC)	Total Expense	Bal Unit	Location	Functional Centre (FC)	Secondary/ Expense	Total Expense		
2A	101	G012	71110103000	\$1,047.37						Total Section B	\$1,047.37
2B										Total Section C&D	
2C										Less Cash Advance	
2D										TOTAL CLAIM	\$1,047.37
				\$1,047.37							

NOTE: This section auto fills from page 2A, 2B, 2C & 2D

NOTE: These fields do not automatically fill for Section C&D

SECTION F: AUTHORIZATION

If applicable, print the name of the person (other than claimant) that prepared the claim along with phone number so if there are any questions contact can be easily made.
 Employee and approver signatures required as well as DOFA level (delegation of authority level) and Position # of the approver.

Claim Prepared by (PRINT ONLY): Jodi Tamayo Phone # _____ Ext _____
 I hereby acknowledge that I have read the "Travel, Hospitality and Working Session Expenses Policy" of Alberta Health Services and hereby confirm that the expenses claimed are in compliance with such policy.
 I hereby certify that the expenses listed above have not been previously claimed by me or on my behalf from Alberta Health Services or other organization.

Employee Signature: _____ Date 31-Dec-12
 I hereby certify that I have reviewed the expenses and they are in accordance with the applicable policies (Policy #'s 1118, 1122).
 Approved claim form with receipts should be sent by the approver directly to Accounts Payable for processing.

Approved By (PRINT ONLY): _____ DOFA Level 2b Position # _____ Phone # _____ Ext _____
 Signature: _____ Title EVP & CMO, Quality and Medical Affairs Date Jan 4/13

Approved By (PRINT ONLY): _____ DOFA Level _____ Position # _____ Phone # _____ Ext _____
 Signature: _____ Title _____ Date _____

Health and Personal Information on this form is collected by AHS under the authority of section 20(1) of the Health Information Act (HIA) and sections 33(a) and 34(2) of the Freedom of Information and Protection of Privacy (FOIP) Act, respectively, for the purposes of administering AHS Programs to Pay program. For more information, questions or concerns about the collection, use or disclosure of your health and personal information, please contact Mark Pellet, Director Accounts Payable at 780-726-0569 or email: Mark.Pellet@ahs.ab.ca

Instruction:

- Attached ALL original detailed receipts and supporting documents in the same order as it appears on this statement
- Cardholder AND Approver's signatures required where indicated below

MACLEAN, VANESSA Cardholder's Name	SOUTH ZONE MEDICAL Cardholder's Position/Title	Billing Reporting Period:	20/12/2012
MEDICAL AFFAIRS Cardholder's Dept	CHINOOK REGIONAL HOSPITAL Cardholder's Site/Location	Total Statement Amount:	
VANESSA.MACLEAN@ALBERTAHEALTHSERVICES.CA Cardholder's e-mail address		Last 6 digits of the P-Card #:	██████████

Statement of Transactions								
Transaction Date	Trans ID	Merchant Name & Description	Trans Original Amount	Currency	Trans Amount	GST	Freight	Description
20/11/2012	301736693	MEDICINE HAT LODGE, LODGING HOTELS, MOTELS, RESORTS	-13.00	CAD	-13.00	.00	.00	Card Erroneously Charged by Hotel- Credit Received

Signatures		
Cardholder Designate (If Applicable) By signing this statement <ul style="list-style-type: none"> I hereby certify that I have reviewed and reconciled this statement in BMO details Online® to the best of my ability in accordance to AHS Corporate Policies, Program User Guide and Training. I have allocated the transaction(s) to the proper cost centre. 		
<u>Jodi Tamayose</u> Name of Cardholder Designate	<u>Executive Coordinator</u> Cardholder Designate Position/Title	<u>Dec 20, 2012</u> Date of Signature
<u>[Signature]</u> Signature of Cardholder Designate		
Cardholder By signing this statement <ul style="list-style-type: none"> I hereby certify that the P-Card issued to be was used for legitimate business purposes in accordance to AHS Corporate Policies and AHS P-Card Program User Guide. I acknowledge that the above Cardholder Designate has completed reviews and reconciliation in BMO details Online® on my behalf (if applicable). 		
<u>MACLEAN, VANESSA</u> Name of Cardholder	<u>SOUTH ZONE MEDICAL</u> Cardholder Position/Title	<u>Dec 21, 2012</u> Date of Signature
<u>[Signature]</u> Signature of Cardholder		
Approver Designate (If Applicable) By signing this statement <ul style="list-style-type: none"> I hereby certify that I have reviewed and approved this statement in BMO details Online® in accordance to AHS Corporate Policies, Program User Guide and Training on behalf of a authorized approver. 		
_____ Name of Approver Designate	_____ Approver Designate Position/Title	_____ Date of Signature
_____ Signature of Approver Designate		
Approver By signing this statement <ul style="list-style-type: none"> I hereby certify that the P-card issued to be was used for legitimate business purposes in accordance to AHS Corporate Policies and AHS P-Card Program User Guide and hereby approve the transactions as listed. I acknowledge that the above Approver Designate has completed reviews and approvals in BMO details Online® on my behalf (if applicable). 		
<u>Dr. Verna [Signature]</u> Name of Approver	<u>EVP + CMO, Quality + Medical Affairs</u> Approver Position/Title	<u>Dec 21/12</u> Date of Signature
<u>[Signature]</u> Signature of Approver		
Submit approved statement with attachments to Accounts Payable:		
Attach: <ul style="list-style-type: none"> Original itemized receipts Signed Cardholder Statement Report (or copies of electronic signatures if signatures are not on report) And where applicable: <ul style="list-style-type: none"> Copies of pre-approvals for travel Personal cheque payable to "Alberta Health Services" Return, refund and/or credit receipts Disputes letter 	Address: Alberta Health Services Accounts Payable 7th Street Plaza 10th Floor, North Tower, 10030-107 Street Edmonton, AB T6J 3E4	
Accounts Payable only		
Reference #:	Reviewed by:	Date:

Dr. Vanessa MacLean

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Checked in Tue Nov 20/12 - 12:07 pm
 Checked out Tue Nov 20/12 - 12:11 pm
 Nights 0
 Room Rate 0.00
 Room ZH10

Date	Description	Reference	Charges	Credits
Nov20	REFUND - Mastercard	miss billed		-13.00
Nov20	Jungle Cafe Charge		-11.54	
Nov20	Gratuities - Jungle Cafe		-1.46	
			0.00	-13.00

Thank you for staying with us. Please come again!
 Call 1 (800) 661-8095 to make your next reservation with us.

Our G.S.T. # is 103576021RT0002

*Card
 erroneously charged
 for meal
 credit.*


MEDICINE HAT LODGE
 1051 ROSS GLEN CR SE
 MEDICINE HAT, AB T1B3T8
 4035428170

Merchant ID: 87212730014
 Term ID: 002
 Ref #: 021

Refund

MASTERCARD
 Entry Method: Manual
 11/20/12
 Inv #: 000021
 11:55:00
 Apprvd
 Batch#: 000184
 Total: \$ 13.00

I agree to pay above total amount
 according to card issuer agreement
 (Merchant agreement IF credit voucher).
 Retain this copy for statement
 verification

X 
 Merchant Signature
 Customer Copy