



SOUTH DAKOTA STATE BOARD OF DENTISTRY  
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### ANESTHESIA INSPECTION TRAVEL EXPENSE REPORT

**YOU MUST COMPLETE A SEPARATE FORM FOR EACH INSPECTION.  
YOU ONLY NEED TO COMPLETE THIS FORM IF YOU HAVE TRAVEL  
EXPENSES FOR THE INSPECTION. YOU DO NOT NEED TO SUBMIT THIS  
FORM FOR PAYMENT OF THE INSPECTION FEE.**

**TOTAL AMOUNT REQUESTED (Total from page 2):** \_\_\_\_\_

**Payee Information:**

Payee Name: \_\_\_\_\_

Payee Address: \_\_\_\_\_

Payee City, State, Zip: \_\_\_\_\_

**Office Inspected Information:**

Licensee(s) Inspected: \_\_\_\_\_

Office Inspected: \_\_\_\_\_

Office Inspected Address: \_\_\_\_\_

Office Inspected City, State, Zip: \_\_\_\_\_

**Inspection Information:**

Inspector Name: \_\_\_\_\_

Date of Inspection: \_\_\_\_\_

**PLEASE CHECK ONE:**

I HAVE SUBMITTED A W-9 FORM FOR THE PAYEE LISTED ABOVE FOR THIS CALENDAR YEAR.

I HAVE NOT SUBMITTED A W-9 FORM THIS CALENDAR YEAR FOR THE PAYEE LISTED ABOVE. MY W-9 FORM IS ATTACHED TO THIS TRAVEL VOUCHER.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## ANESTHESIA TRAVEL EXPENSES

<b>Lodging</b>	<i>Receipt Required: You may claim reimbursement for one night at a hotel up to \$125.00.</i>				
<b>DATE</b>	<b>HOTEL</b>				<b>TOTAL</b>
					\$
<b>TOTAL LODGING:</b>					
<b>Meals</b>	<i>Per Diem (No Receipt Required):</i>				
		<u>Leave</u>		<u>Return</u>	
	<i>Breakfast \$6.00</i>	<i>before 5:31 AM</i>		<i>after 7:59 AM</i>	
	<i>Lunch \$14.00</i>	<i>before 11:31 AM</i>		<i>after 12:59 PM</i>	
	<i>Dinner \$20.00</i>	<i>before 5:31 PM</i>		<i>after 7:59 PM</i>	
<b>DATE</b>	<b>TIME</b> LEAVE-- RETURN	<b>BREAKFAST</b>	<b>LUNCH</b>	<b>DINNER</b>	<b>TOTAL</b>
		\$	\$	\$	\$
		\$	\$	\$	\$
<b>TOTAL MEALS:</b>					
<b>Mileage</b>	<i>Mileage is reimbursed at \$.42 per mile</i>				
<b>DATE</b>		<b>FROM (CITY)</b>	<b>TO (CITY)</b>	<b># MILES</b>	<b>RATE</b>
					.42
					\$
					.42
					\$
<b>TOTAL MILEAGE:</b>					
<b>TOTAL:</b>					