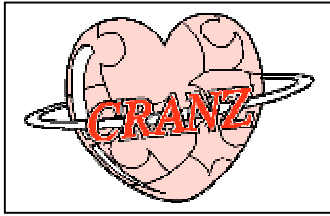


Cardiac Rehabilitation Association of New Zealand



Expense Claim Form

Date:

Name:

Address:
(to send cheque to)
.....

Activity/claim relates to:.....
.....
.....

Expense Details

What:	Approved by:	Cost:
Please attach all receipts	Total claimed:	

Claimants signature:	Approved by:	Date:
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Please fax to:

Fax: 03 474 7794
Attn: Leanne Barclay
President Elect CRANZ
c/- Dunedin Hospital
Cardiology Department
201 Great King Street
Dunedin

The President will pass onto the Treasurer for reimbursement. Your cheque will be posted to above address