



# APPLICANT COPY

## Payment Requisition

Accounting Services  
10<sup>th</sup> Floor, North Tower CHC  
10030-107 St.  
Edmonton, Alberta T5J 3E4

<b>I PAYEE INFORMATION</b>	Check one only) <input type="checkbox"/> Vendor <input type="checkbox"/> Patient <input checked="" type="checkbox"/> Employee (EE number)																								
Invoice Date 24-Mar-06	Invoice Number	s.17(1), 17(4)(g)(i)																							
Vendor Number (or)	Payee Name <b>Glenda Coleman-Miller</b>																								
Address	s.17(1), 17(4)(g)(i)		City																						
Province/State	Postal Code	Country <b>Canada</b>																							
<b>II PAYMENT DETAILS</b>	Reason for payment: <b>Reimbursement of conference costs paid by personal credit</b> PO #																								
Is this a contract payment?	<input type="checkbox"/> Yes (Attach copy of contract if not previously forwarded) <input checked="" type="checkbox"/> No																								
If this is a contract payment, what is the contract date?	Number																								
Have goods / services been received?	<input type="checkbox"/> Yes, When? <input type="checkbox"/> No																								
Are original attachments mailed with cheque? (Note 2)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																								
<b>III EXPENSE CODES</b>	<b>RACALE FINANCIAL SYSTEM FORMAT</b> (Departments must provide Complete Coding)																								
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Bal Unit e.g. 201</th> <th>Location e.g. 9000</th> <th>Functional Centre e.g. 71135050044</th> <th>Account e.g. 69500001</th> <th>Expense Sub-Total</th> <th>GST if applicable</th> <th>Total Payment</th> </tr> </thead> <tbody> <tr> <td>201</td> <td>0002</td> <td>1001</td> <td>61030000</td> <td>\$655.51</td> <td>\$45.89</td> <td>\$701.40</td> </tr> <tr> <td colspan="3"></td> <td><b>TOTAL</b></td> <td><b>\$655.51</b></td> <td><b>\$45.89</b></td> <td><b>\$701.40</b></td> </tr> </tbody> </table>	Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Expense Sub-Total	GST if applicable	Total Payment	201	0002	1001	61030000	\$655.51	\$45.89	\$701.40				<b>TOTAL</b>	<b>\$655.51</b>	<b>\$45.89</b>	<b>\$701.40</b>				
Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Expense Sub-Total	GST if applicable	Total Payment																			
201	0002	1001	61030000	\$655.51	\$45.89	\$701.40																			
			<b>TOTAL</b>	<b>\$655.51</b>	<b>\$45.89</b>	<b>\$701.40</b>																			
<input checked="" type="checkbox"/> Canadian <input type="checkbox"/> Other																									
<b>IV AUTHORIZATION</b>	I confirm that the above have not been previously paid and the expenses related only to Capital Health business.																								
Requisitioned by (Print Name)	<b>Aileen Savage</b>		Phone # <b>735-5272</b>																						
(Signature)	<i>Aileen Savage</i>		Date <b>27-Mar-06</b>																						
Approved by (Print Name)	<b>Glenda Coleman-Miller</b>		Phone # <b>735.5272</b>																						
(Signature)	<i>Glenda Coleman-Miller</i>		Date <b>28-Mar-06</b>																						
Approved by (Print Name)	<b>Joanna Pawlyshyn</b>		Phone # <b>735-4101</b>																						
(Signature)	<i>Joanna Pawlyshyn</i>		Date <b>29 Mar 06</b>																						
<b>AUTHORIZATIONS SHOULD BE IN ACCORDANCE WITH SIGNING AUTHORITY POLICY NUMBER FINANCE 4.1</b>																									
Notes:	1) All employee payments to be made electronically based on payroll banking information. 2) All cheques and attachments to be mailed out by Accounting Services. Cheques will NOT be pulled and returned to departments for mailing. 3) Fully completed payment requisitions received in Accounting Services by <b>MONDAY, 4:00 p.m.</b> will be processed that week. 4) <b>Incomplete/improperly completed payment requisitions will be returned without processing</b>																								

Capital Health

**RECEIVED**

MAR 31 2006

ACCOUNTS PAYABLE

**Receipt**  
APPLICANT COPY



Canadian Nurses Association

50 DRIVEWAY  
OTTAWA ON K2P 1E2  
Tel: (613) 237-2133 Fax: (613) 237-3520

GLENDACOLEMAN-MILLER  
SENIOR OPERATIONS OFFICER  
CAPITAL HEALTH SERVICES  
KINGSWAY  
10240 KINGSWAY  
EDMONTON AB T5A 0A9

Receipt Printed: 2006-03-17  
Registration Number:  
s.17(1), 17(4)(g)(i)

CNA 2006 Biennial Convention and Annual Meeting

**Sessions** **Services pour GLENDA COLEMAN-MILLER**

Title	Date	Qty/Qté	Price/Prix
Registration/Participation complete	2006-06-18	1	\$520.00
Medical Nursing / médicaux-chirurgicaux	2006-06-18	1	\$70.09
Event/Billet pour banquet	2006-06-20	1	\$65.42
International Health Luncheon / Déjeuner internationaux	2006-06-21	1	\$0.00

Total Before Taxes: \$655.51  
GST/TPS: \$45.89  
Total Billed: \$701.40  
Total Paid: \$701.40

**Balance: \$0.00**

GST No: 140 000 000

*Paid by personal credit card of:  
Glenda Coleman-Miller*



# APPLICANT COPY

Accounting Services  
10<sup>th</sup> Floor, North Tower CHC  
10030-107 St.  
Edmonton, Alberta T5J 3E4

## Payment Requisition

**I PAYEE INFORMATION** (Check one only)  Vendor  Patient  Employee (EE number)

Invoice Date **5-Jul-06** (DD-MMM-YY) Invoice Number **s.17(1), 17(4)(g)(i)**  
 Vendor Number (or S.I.N.) Payee Name **Glenda Coleman-Miller**  
 Address **s.17(1), 17(4)(g)(i)** City  
 Province/State Postal Code Country

**II PAYMENT DETAILS**

Reason for payment **Mileage - April - June, 2006 - 434 km @.43 km = \$186.62** PO #  
~~Mileage~~ **Parking - April - June, 2006 - \$113.30**  
 Is this a contract payment?  Yes (Attach copy of contract if not previously forwarded)  No  
 If this is a contract payment, what is the contract date? Number  
 Have goods / services been received?  Yes, When?  No  
 Are original attachments to be mailed with cheque? (Note 2)  Yes  No

**III EXPENSE CODES (IN ORACLE FINANCIAL SYSTEM FORMAT)** (Departments must provide Complete Coding)

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Expense Sub-Total	GST if applicable	Total Payment
201	0002	71110101001	62410000	\$186.62		\$186.62
201	0002	71110101001	62410000	113.30		113.30

Capital Health  
**RECEIVED**  
JUL 20 2006  
ACCOUNTS  
PAYABLE

Canadian  U.S.  Other **TOTAL \$299.92** **(T) \$299.92**

**IV AUTHORIZATION**

I confirm that the above items have not been previously paid and the expenses related only to Capital Health business.

Requisitioned by (Print name) **Aileen Savage** Phone # **735-5272**  
 (Signature) *Aileen Savage* Date **5-Jul-06**  
 Approved by (Print name) **Glenda Coleman-Miller** Phone # **735-5272**  
 (Signature) *Glenda Coleman-Miller* Date **06-07-06**  
 Approved by (Print name) **Joanna Pawlyshyn** Phone # **735-4101**  
 (Signature) *Joanna Pawlyshyn* Date **17 July 06**

**AUTHORIZATIONS SHOULD BE IN ACCORDANCE WITH SIGNING AUTHORITY POLICY NUMBER FINANCE 4.1**

- Notes:
- 1) All employee payments will be made electronically based on payroll banking information.
  - 2) All cheques and attachments will be mailed out by Accounting Services. Cheques will NOT be pulled and returned to departments for mailing.
  - 3) Fully completed payment requisitions received in Accounting Services by **MONDAY, 4:00 p.m.** will be processed that week.
  - 4) **Incomplete/improperly authorized payment requisitions will be returned without processing**

APPLICANT COPY



MILEAGE AND PARKING CLAIM FORM (WITHIN REGION)

Program <i>EXEC</i>	Employee Name <i>Glenda Coleman-Miller</i>	Location <i>RAH</i>	Payroll #
------------------------	---	------------------------	-----------

s.17(1), 17(4)(g)(i)

NOTE: 1) It is the employee's responsibility to maintain adequate records to substantiate all mileage claims to Revenue Canada, Program Management, or Finance upon request. You must be able to provide documentation which shows the date, destination and km travelled on each of your trips.  
2) Driving to and from work is not considered business travel and must not be claimed.

Month <i>April</i>	Year <i>2006</i>
-----------------------	---------------------

Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	Date	KM	Parking
1			9			17			25		
2			10			18			26		
3			11			19			27	<i>16</i>	
4	<i>16</i>		12	<i>16</i>	<i>5.00</i> ✓	20	<i>6</i>	<i>12.00</i> ✓	28		
5			13			21			29		
6			14			22			30		
7			15			23			31		
8			16			24	<i>60</i>	<i>12.40</i> ✓			
Total									<i>114</i>	<i>39.40</i> ✓	

Declaration: I hereby certify that the mileage and parking charges listed above were incurred on Capital Health business and that the amount has not been previously claimed by me or on my behalf.

APPLICANT COPY

EDMONTON AIRPORTS  
GST # R108102831

CITY OF EDMONTON  
LIBRARY PARKADE  
GST # 119326270 RT0001

\*\*\*\*\*  
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0000000000 Phone: (780) 443-1111  
Fax: (780) 443-1111

Rcpt# 40379  
04/20/06 15:11 L# 2 A# 12 Tyn#131540  
04/20/06 10:35 In 04/20/06 15:11 Out  
Tkt# 585608  
Regular Rate \$ 11.21  
Total Tax \$ 0.79  
Total Fee \$ 12.00  
CASH PAID \$ 12.00-  
Cash Tender \$ 22.00  
Change Due \$ 10.00  
THANK YOU  
COME AGAIN

**Best Copy Possible**  
12.40  
21 Min.  
12.40  
12.40  
0.00

Thank you for your purchase  
We hope you enjoyed your trip  
We look forward to serving you again  
Thank you

GST # R108102831

RECEIPT

ALBERTA  
UNIVERSITY OF



CREDIT CARD NUMBER s.17(1), 17(4)(c.1)

12/04/06 09:29 AM \$ 5.00  
DATE ISSUED TIME ISSUED AMOUNT PAID

DETACH RECEIPT FROM TICKET

NON TRANSFERABLE

ALBERTA  
UNIVERSITY OF



\$ 5.00 1521000009:29 AM

12/04 11:29 AM  
EXPIRATION DATE EXPIRATION TIME

DISPLAY THIS SIDE UP ON DASHBOARD

APPLICANT COPY



**MILEAGE AND PARKING CLAIM FORM (WITHIN REGION)**

Program <i>EXEC</i>	Employee Name <i>Glenda Coleman-Miller</i>	Location <i>BAH</i>	Payroll #
------------------------	---	------------------------	-----------

s.17(1), 17(4)(g)(i)

**NOTE: 1) It is the employee's responsibility to maintain adequate records to substantiate all mileage claims to Revenue Canada, Program Management, or Finance upon request. You must be able to provide documentation which shows the date, destination and km travelled on each of your trips.**  
**2) Driving to and from work is not considered business travel and must not be claimed.**

Month <i>May</i>	Year <i>2006</i>
---------------------	---------------------

Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	Date	KM	Parking
1			9	<i>16</i>		17	<i>10</i>		25		
2			10			18			26		
3			11	<i>22</i>		19			27		
4			12			20			28		
5		<i>6.00</i>	13			21			29		
6			14			22			30	<i>16</i>	<i>6.00</i>
7			15	<i>16</i>	<i>6.00</i>	23	<i>32</i>	<i>9.90</i>	31		
8	<i>32</i>		16			24	<i>32</i>	<i>9.45</i>			

Total	<i>176</i>	<i>37.35</i>
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**Declaration: I hereby certify that the mileage and parking charges listed above were incurred on Capital Health business and that the amount has not been previously claimed by me or on my behalf.**

APPLICANT COPY

CAPITAL HEALTH  
UNIVERSITY HOSPITAL PUBLIC PARKING

Report# 5535  
05/24/06 14:01 LH 1 AM 2 Txn# 23120  
05/24/06 12:25 In 05/24/06 14:01 Out  
TK# 765230  
Daily Rate \$ 5.40  
Total Fee \$ 5.40  
CASH PAID \$ 5.40-  
Cash Tender \$ 5.40  
Change Due \$ 0.00

CAPITAL HEALTH  
UNIVERSITY HOSPITAL PUBLIC PARKING

Report# 5500  
05/24/06 10:49 LH 1 AM 2 Txn# 22992  
05/24/06 09:16 In 05/24/06 10:49 Out  
TK# 765902  
Daily Rate \$ 4.05  
Total Fee \$ 4.05  
CASH PAID \$ 4.05-  
Cash Tender \$ 4.05  
Change Due \$ 0.00

UNIVERSITY OF ALBERTA  
HOSPITAL 83 AVE  
THANK YOU FOR PARKING

Report# 30553  
05/23/06 14:45 LH 1 AM 3 Txn#100576  
05/23/06 13:08 In 05/23/06 14:45 Out  
TK# 765028  
Daily Rate \$ 5.40  
Total Fee \$ 5.40  
CASH PAID \$ 5.40-  
Cash Tender \$ 6.00  
Change Due \$ 0.60

UNIVERSITY OF ALBERTA  
HOSPITAL 114 ST.  
THANK YOU FOR PARKING

Report# 15179  
05/23/06 14:57 LH 1 AM 3 Txn# 95791  
05/23/06 13:41 In 05/23/06 14:57 Out  
Lost Fee 01 \$ 4.50  
Total Fee \$ 4.50  
CASH PAID \$ 4.50-  
Cash Tender \$ 4.50  
Change Due \$ 0.00

UNIVERSITY OF ALBERTA  
HOSPITAL 114 St.  
THANK YOU FOR PARKING

Report# 15348  
05/15/06 18:05 LH 1 AM 3 Txn# 81240  
05/15/06 16:26 In 05/15/06 18:05 Out  
Lost Fee 01 \$ 6.00  
Total Fee \$ 6.00  
CASH PAID \$ 6.00-  
Cash Tender \$ 6.00  
Change Due \$ 0.00

*Safer Healthcare Now*

**DISPLAY FACE UP ON DASH RECEIPT**

**Imperial Parking**  
 Lot 0002-161  
 CST #88731 5638 RT0001  
 Machine Serial #000004461011

EXPIRY DATE AND TIME      Exp 06:00pm  
 M./ 30,2006  
 C/

**EXP 06:00pm**  
**MAY 30,2006**

TICKET#      LOT#  
 00001090      00020161

C/ \$0006.00 Visa      MACH# 002  
 EXP # INSTRUCTIONS ON SIGNS POSTED      C/ \$0006.00  
 M./ 30,2006  
 C/ 2lan  
 P/ chase line

s.17(1), 17(4)(e.1)  
**Early Bird \$6.00**  
 Questions/Comments  
 Call 780-420-1976

**DISPLAY FACE UP ON DASH RECEIPT**

s.17(1), 17(4)(e.1)

**150 MIN**

Amount Pd: 6.00

Licence \_\_\_\_\_ Prov. \_\_\_\_\_

Make \_\_\_\_\_ Color \_\_\_\_\_

Date \_\_\_\_\_

**No 100892**

**600000000000**



APPLICANT COPY



**MILEAGE AND PARKING CLAIM FORM (WITHIN REGION)**

Program <i>EXEC</i>	Employee Name <i>Glenda Coleman-Miller</i>	Location <i>RAH</i>	Payroll #
------------------------	---	------------------------	-----------

s.17(1), 17(4)(g)(i)

NOTE: 1) It is the employee's responsibility to maintain adequate records to substantiate all mileage claims to Revenue Canada, Program Management, or Finance upon request. You must be able to provide documentation which shows the date, destination and km travelled on each of your trips.  
2) Driving to and from work is not considered business travel and must not be claimed.

Month <i>JUNE</i>	Year <i>2006</i>
----------------------	---------------------

Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	Date	KM	Parking			
1			9			17			25					
2			10			18			26					
3			11			19			27	<i>32</i>	<i>12.15</i> ✓			
4			12			20			28	<i>16</i>	<i>10.00</i> ✓			
5			13			21			29	<i>32</i>	<i>9.90</i> ✓			
6	<i>16</i>	<i>10.00</i> ✓	14			22			30					
7	<i>16</i>		15	<i>16</i>		23			31					
8			16	<i>16</i>	<i>4.50</i> ✓	24			<table border="1"> <tr> <td>Total</td> <td><i>144</i></td> <td><i>46.55</i> ✓</td> </tr> </table>			Total	<i>144</i>	<i>46.55</i> ✓
Total	<i>144</i>	<i>46.55</i> ✓												

Declaration: I hereby certify that the mileage and parking charges listed above were incurred on Capital Health business and that the amount has not been previously claimed by me or on my behalf.

UNIVERSITY OF ALBERTA  
 PARKING SERVICES  
 GST# R108102831

UNIVERSITY OF ALBERTA  
 PARKING SERVICES  
**PERMIT**

UNIVERSITY OF ALBERTA  
 DEPT. TA 112 ST  
 EDMONTON, ALBERTA  
 T6N 1N6 J8R CANADA

UNIVERSITY OF ALBERTA  
 DEPT. TA 112 ST  
 EDMONTON, ALBERTA  
 T6N 1N6 J8R CANADA

06-06-2006 THE #1

**DASH**  
**E UP**

DP-06 10.00 5  
 GST 0.65  
 CASH 10.00  
**129251**

ITEM 1 3999 07:40TH 16

Parking

Help prevent crime. Remove all valuables. Lock your car.  
 \*\* See reverse for Limitation of Liability \*\*

UNIVERSITY OF ALBERTA  
 PARKING SERVICES  
**129251**  
 GST# R108102831  
**DAILY PARKING PERMIT - RECEIPT**  
 CUSTOMER RECEIPT: \$ \_\_\_\_\_

Best Copy Possible

SCHE 5942  
 06/15/06 14:17 W 1 1 1 1  
 06/21/06 09:57 W 0 1 1 1  
 1974 00141  
 DAILY FEE \$ 4.50  
 TOTAL FEE \$ 4.50  
 REG FEE \$ 4.50  
 DASH 10-15-07 \$ 20.00  
 CHANGE DTS \$ 18.50

SCHE 5942  
 06/22/06 11:17 W 1 1 1 1  
 06/28/06 09:41 W 0 1 1 1  
 1974 00125  
 DAILY FEE \$ 4.50  
 TOTAL FEE \$ 4.50  
 REG FEE \$ 4.50  
 DASH 10-15-07 \$ 20.00  
 CHANGE DTS \$ 18.50

PROPERTY OF ALBEM  
HEBERT, G. W.  
DANK VLL FOR OKCOK

Best Copy Possible

APRIL 1962  
5/27/06 18:04 LN 1 4# 3 TXM112125  
05/27/06 18:04 LN 1 05/27/06 18:04 CP  
TOTAL PAID 3 11.00  
DAILY PAID 3 11.00  
TOTAL FEE 3 11.00  
DANK PAID 3 11.00  
DANK PAID 3 11.00  
DANK PAID 3 11.00  
DANK PAID 3 11.00

PROPERTY OF ALBEM  
HEBERT, G. W.  
DANK VLL FOR OKCOK

Best Copy Possible

APRIL 1962  
05/27/06 18:04 LN 1 4# 2 TXM112122  
05/27/06 18:04 LN 1 05/27/06 18:04 CP  
TOTAL PAID 1 4.05  
DAILY PAID 1 4.05  
TOTAL FEE 1 4.05  
DANK PAID 1 4.05  
DANK PAID 1 4.05  
DANK PAID 1 4.05  
DANK PAID 1 4.05

PROPERTY OF ALBEM  
HEBERT, G. W.  
DANK VLL FOR OKCOK

Best Copy Possible

APRIL 1962  
5/27/06 18:04 LN 1 4# 5 TXM112129  
05/27/06 18:04 LN 1 05/27/06 18:04 CP  
TOTAL PAID 3 8.10  
DAILY PAID 3 8.10  
TOTAL FEE 3 8.10  
DANK PAID 3 8.10  
DANK PAID 3 8.10  
DANK PAID 3 8.10  
DANK PAID 3 8.10

PROPERTY OF ALBEM  
HEBERT, G. W.  
DANK VLL FOR OKCOK

Best Copy Possible

APRIL 1962  
05/27/06 18:04 LN 1 4# 5 TXM112129  
05/27/06 18:04 LN 1 05/27/06 18:04 CP  
TOTAL PAID 3 8.10  
DAILY PAID 3 8.10  
TOTAL FEE 3 8.10  
DANK PAID 3 8.10  
DANK PAID 3 8.10  
DANK PAID 3 8.10  
DANK PAID 3 8.10



# APPLICANT COPY

Accounting Services  
10<sup>th</sup> Floor, North Tower CHC  
10030-107 St.  
Edmonton, Alberta T5J 3E4

## Payment Requisition

**I PAYEE INFORMATION** (Check one only)  Vendor  Patient  Employee (EE number)

Invoice Date ~~5-Jul-06~~ <sup>14 JUL 06</sup> (DD-MMM-YY) Invoice Number **REIMBURSE - 14 JUL 06** s.17(1), 17(4)(g)(i)

Vendor Number (or S.I.N.) Payee Name **Glenda Coleman-Miller**

Address s.17(1), 17(4)(g)(i) City

Province/State Postal Code Country

### II PAYMENT DETAILS

Reason for payment **Dinner Expense for Dr. Voth - Chair of Ethics Committee** **RECOGNITION DINNER FOR DR VOTH'S TIME AS** PO#

Is this a contract payment?  Yes (Attach copy of contract if not previously forwarded)  No

If this is a contract payment, what is the contract date? Number

Have goods / services been received?  Yes, When? **June 14, 2006**  No

Are original attachments to be mailed with cheque? (Note 2)  Yes  No

### III EXPENSE CODES (IN ORACLE FINANCIAL SYSTEM FORMAT)

(Departments must provide Complete Coding)

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Expense Sub-Total	GST if applicable	Total Payment
201	0002	71110101001	69500000	\$568.17		\$568.17
<p>ATTENDEES @ DINNER:</p> <p>DR VOTH J. PAWLYSHYN</p> <p>DR DICKOUT G. COLEMAN-MILLER</p> <p>DR MATHESON N. ELLFORD</p> <p>G. GOLDSAND</p>						
<input checked="" type="checkbox"/> Canadian <input type="checkbox"/> U.S. <input type="checkbox"/> Other				TOTAL	\$568.17	\$568.17

### IV AUTHORIZATION

I confirm that the above items have not been previously paid and the expenses related only to Capital Health business.

Requisitioned by (Print name) **Aileen Savage** Phone # **735-5272**

(Signature) *Aileen Savage* Date **5-Jul-06**

Approved by (Print name) **Glenda Coleman-Miller** Phone # **735-5271**

(Signature) *Glenda Coleman-Miller* Date **06-07-06**

Approved by (Print name) **Joanna Pawlyshyn** Phone # **735-4101**

(Signature) *Joanna Pawlyshyn* Date **17 July 06**

Capital Health  
**RECEIVED**  
JUL 20 2006  
**ACCOUNTS PAYABLE**

AUTHORIZATIONS SHOULD BE IN ACCORDANCE WITH SIGNING AUTHORITY POLICY NUMBER FINANCE 4.1

- Notes:
- 1) All employee payments will be made electronically based on payroll banking information.
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  - 4) **Incomplete/improperly authorized payment requisitions will be returned without processing**

APPLICANT COPY

*dinner for Dr. Voth*

CHARACTERS REST  
10277 - 105 STREET  
EDMONTON, AB.

T5J 1E3

780-421-4100

GST# 89206-4429

JUN 14 '06 08:43PM

M/T

TABLE

NO.

ALL #

EX. DATE

PAID

CHECK

TAX

SERVER

12/1

6/5/16

1/3

11/1

130 LOLE 5

GLENDIA COLEMAN-MILLER

Subtotal. 503.17

GRATUITY 65.00

TOTAL 568.17

SIGNATURE  
\*\* Customer Copy \*\*



# APPLICANT COPY

Accounting Services  
 10<sup>th</sup> Floor, North Tower CHC  
 10030-137 St.  
 Edmonton, Alberta T5J-8E4

## Payment Requisition

<b>I PAYEE INFORMATION</b> (Check one only)							<input type="checkbox"/> Vendor	<input type="checkbox"/> Patient	<input checked="" type="checkbox"/> Employee (EE number)
Invoice Date <b>5-Jul-06</b> (DD-MMM-YY)				Invoice Number s.17(1), 17(4)(g)(i)					
Vendor Number (or S.I.N.)				Payee Name <b>Glenda Coleman-Miller</b>					
Address				s.17(1), 17(4)(g)(i)			City		
Province/State				Postal Code <b>T6E 4R4</b>			Country		
<b>II PAYMENT DETAILS</b>									
Reason for payment <b>CNA Biennial Convention - Saskatoon - Accommodation &amp; Meals</b>								PO #	
Is this a contract payment? <input type="checkbox"/> Yes (Attach copy of contract if not previously forwarded) <input type="checkbox"/> No									
If this is a contract payment, what is the contract date?								Number	
Have goods / services been received? <input checked="" type="checkbox"/> Yes When? <b>22-Jun-06</b> <input type="checkbox"/> No									
Are original attachments to be mailed with cheque? (Note-2) <input type="checkbox"/> Yes <input type="checkbox"/> No									
<b>III EXPENSE CODES (IN ORACLE FINANCIAL SYSTEM FORMAT)</b>							(Departments must provide Complete Coding)		
Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Expense Sub-Total	GST if applicable	Total Payment			
<b>201</b>	<b>0002</b>	<b>71110101001</b>	<b>62400000</b>	<b>\$772.94</b>		<b>\$772.94</b>			
			<b>62414000</b>						
<div style="border: 2px solid black; padding: 5px; display: inline-block;">           Capital Health  <b>RECEIVED</b>            JUL 20 2006            ACCOUNTS            PAYABLE         </div>									
<input checked="" type="checkbox"/> Canadian	<input type="checkbox"/> U.S.	<input type="checkbox"/> Other	<b>TOTAL</b>	<b>\$772.94</b>		<b>\$772.94</b>			
<b>IV AUTHORIZATION</b>									
I confirm that the above items have not been previously paid and the expenses related only to Capital Health business.									
Requisitioned by (Print name) <b>Aileen Savage</b>				<b>132.56</b>		Phone # <b>735-5272</b>			
(Signature) <i>Aileen Savage</i>						Date <b>5-Jul-06</b>			
Approved by (Print name) <b>Glenda Coleman-Miller</b>				<b>40.38</b>		Phone # <b>735-5271</b>			
(Signature) <i>Glenda Coleman-Miller</i>						Date <b>06-07-06</b>			
Approved by (Print name) <b>Joanna Pawlyshyn</b>						Phone # <b>735-4101</b>			
(Signature) <i>Joanna Pawlyshyn</i>				<b>17 July 06</b>		Date			
<b>AUTHORIZATIONS SHOULD BE IN ACCORDANCE WITH SIGNING AUTHORITY POLICY NUMBER FINANCE 4.1</b>									
Notes:									
1) All employee payments will be made electronically based on payroll banking information. 2) All cheques and attachments will be mailed out by Accounting Services. Cheques will NOT be pulled and returned to departments for mailing. 3) Fully completed payment requisitions received in Accounting Services by <b>MONDAY, 4:00 p.m.</b> will be processed that week. 4) <b>Incomplete/improperly authorized payment requisitions will be returned without processing</b>									

Name & Address

COLEMAN MILLER, GLENDA

s.17(1), 17(4)(g)(i)

Room 1006/Q2  
Arrival Date 06/18/06 4:33PM  
Departure Date 06/22/06

Adult/Child 1/0  
Room Rate 144.00

CDN NURSES ASSOC

RATE PLAN C-NURSES

HH#

AL:

BONUS AL: CAR:

CONFIRMATION NUMBER : 3227300594

06/22/06 PAGE 1

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DATE	REFERENCE	AUDIT	DESCRIPTION	AMOUNT	AMOUNT
06/18/06	PARKING		209072	\$8.00	
06/18/06	GOODS AND SERVICE TAX	AUDIT	209072	\$0.56	
06/18/06	GUEST ROOM	AUDIT	209073	\$144.00	
06/18/06	RM - GOODS AND SERVICES TAX	AUDIT	209073	\$10.08	
06/18/06	RM - PROVINCIAL SALES TAX	AUDIT	209073	\$10.08	
06/18/06	DESTINATION MARKETING FEE	AUDIT	209073	\$3.28	
06/19/06	*ROOM SERVICE	LINTR	209581	\$20.21	
06/19/06	PARKING	AUDIT	209779	\$8.00	
06/19/06	GOODS AND SERVICE TAX	AUDIT	209779	\$0.56	
06/19/06	GUEST ROOM	AUDIT	209780	\$144.00	
06/19/06	RM - GOODS AND SERVICES TAX	AUDIT	209780	\$10.08	
06/19/06	RM - PROVINCIAL SALES TAX	AUDIT	209780	\$10.08	
06/19/06	DESTINATION MARKETING FEE	AUDIT	209780	\$3.28	
06/20/06	*GREAT NORTH AMERICAN GRILL	LINTR	210149	\$14.79	
06/20/06	*GREAT NORTH AMERICAN GRILL	LINTR	210260	\$12.70	
06/20/06	PARKING	AUDIT	210554	\$8.00	
06/20/06	GOODS AND SERVICE TAX	AUDIT	210554	\$0.56	
06/20/06	GUEST ROOM	AUDIT	210555	\$144.00	
06/20/06	RM - GOODS AND SERVICES TAX	AUDIT	210555	\$10.08	

**Zip-Out Check-Out®**

Good Morning ! We hope you enjoyed your stay. With Zip-Out Check-Out® there is no need to stop at the Front Desk to check out.

- Please review this statement. It is a record of your charges as of late last evening.
- For any charges after your account was prepared, you may:
  - + pay at the time of purchase.
  - + charge purchases to your account, then stop by the Front Desk for an updated statement.
  - + or request an updated statement be mailed to you within two business days.

If the statement meets with your approval, simply press the Zip-Out Check-Out button on your guest room telephone. Your account will be automatically checked out and you may use this statement as your receipt. Feel free to leave your key(s) in the room. Please call the Front Desk if you wish to extend your stay or if you have any questions about your account.

DATE OF CHARGE	FOLIO NO./CHECK NO. 49898 A	
AUTHORIZATION	INITIAL	
PURCHASES & SERVICES		
TAXES		
TIPS & MISC.		
TOTAL AMOUNT		

Name & Address

COLEMAN MILLER, GLENDA

s.17(1), 17(4)(g)(i)

Room 1006/Q2  
Arrival Date 06/18/06 4:33PM  
Departure Date 06/22/06  
Adult/Child 1/0  
Room Rate 144.00

CDN NURSES ASSOC

RATE PLAN C-NURSES

HH#

AL:

BONUS AL:

CAR:

CONFIRMATION NUMBER : 3227300594

06/22/06 PAGE 2

DATE	REFERENCE	DESCRIPTION	AUDIT	AMOUNT
06/20/06	RM - PROVINCIAL SALES TAX	210555	AUDIT	\$10.08
06/20/06	DESTINATION MARKETING FEE	210555	AUDIT	\$3.28
06/21/06	GREAT NORTH AMERICAN GRILL	210997	LINTR	\$12.54
06/21/06	TELEPHONE-LD (INTERSTATE)	211130	LINTR	\$0.83
06/21/06	GOODS AND SERVICE TAX	211130	LINTR	\$0.06
06/21/06	PROVINCIAL SALES TAX	211130	LINTR	\$0.06
06/21/06	VALET LAUNDRY	211245	ERIN	\$7.24
06/21/06	GOODS AND SERVICE TAX	211245	ERIN	\$0.51
06/21/06	PARKING	211301	AUDIT	\$8.00
06/21/06	GOODS AND SERVICE TAX	211301	AUDIT	\$0.56
06/21/06	GUEST ROOM	211302	AUDIT	\$144.00
06/21/06	RM - GOODS AND SERVICES TAX	211302	AUDIT	\$10.08
06/21/06	RM - PROVINCIAL SALES TAX	211302	AUDIT	\$10.08
06/21/06	DESTINATION MARKETING FEE	211302	AUDIT	\$3.28
WILL BE SETTLED TO VS EFFECTIVE BALANCE OF				\$772.94
EXPENSE REPORT SUMMARY				\$0.00
06/18/06	06/19/06	06/20/06	06/21/06	STAY TOTAL

s.17(1), 17(4)(e.1)

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DATE OF CHARGE	FOLIO NO./CHECK NO. 49898 A
AUTHORIZATION	INITIAL
PURCHASES & SERVICES	
TAXES	
TIPS & MISC.	
TOTAL AMOUNT	



Name & Address

COLEMAN MILLER, GLENDA

s.17(1), 17(4)(g)(i)

Room 1006/Q2  
 Arrival Date 06/18/06 4:33PM  
 Departure Date 06/22/06

Adult/Child 1/0  
 Room Rate 144.00

CDN NURSES ASSOC

RATE PLAN C-NURSES

HH#

AL:

BONUS AL:

CAR:

CONFIRMATION NUMBER : 3227300594

06/22/06 PAGE 3

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DATE	REFERENCE	DESCRIPTION				AMOUNT
ROOM & TAX		\$167.44	\$167.44	\$167.44	\$167.44	\$669.76
TELEPHONE		\$0.00	\$0.00	\$0.00	\$0.83	\$0.83
MISCELLANEOUS		\$8.00	\$8.00	\$8.00	\$15.24	\$39.24
FOOD & BEVERAGE		\$0.00	\$20.21	\$27.49	\$12.54	\$60.24
OTHER		\$0.56	\$0.56	\$0.56	\$1.19	\$2.87
DAILY TOTAL		\$176.00	\$196.21	\$203.49	\$197.24	\$772.94
	06/30/06					
ROOM & TAX		\$0.00				
DAILY TOTAL		\$0.00				

**Zip-Out Check-Out®**

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DATE OF CHARGE	FOLIO NO./CHECK NO. 49898 A	
AUTHORIZATION	INITIAL	
PURCHASES & SERVICES		
TAXES		
TIPS & MISC.		
TOTAL AMOUNT		



# APPLICANT COPY

Accounting Services  
10<sup>th</sup> Floor, North Tower CHC  
10030-107 St.  
Edmonton, Alberta T5J 3E4

## Payment Requisition

<b>I PAYEE INFORMATION</b> (Check one only)		<input type="checkbox"/> Vendor	<input type="checkbox"/> Patient	<input checked="" type="checkbox"/> Employee (EE number		
Invoice Date <b>02-AUG-06</b> (DD-MMM-YY)	Invoice Number			s.17(1), 17(4)(g)(i)		
Vendor Number (or S.I.N.)	Payee Name <b>Glenda Coleman-Miller</b>					
Address	s.17(1), 17(4)(g)(i)		City			
Province/State	Postal Code	Country				
<b>II PAYMENT DETAILS</b>						
Reason for payment <b>Halifax 6 Conference Registration</b>			PO #			
Is this a contract payment? <input type="checkbox"/> Yes (Attach copy of contract if not previously forwarded) <input checked="" type="checkbox"/> No						
If this is a contract payment, what is the contract date?			Number			
Have goods / services been received? <input checked="" type="checkbox"/> Yes, When? <b>1-Oct-06</b> <input type="checkbox"/> No						
Are original attachments to be mailed with cheque? (Note 2) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
<b>III EXPENSE CODES (IN ORACLE FINANCIAL SYSTEM FORMAT)</b> (Departments must provide Complete Coding)						
Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Expense Sub-Total	GST if applicable	Total Payment
<b>201</b>	<b>0002</b>	<b>711110101001</b>	<b>61030000</b>	<b>\$830.00</b>		<b>\$830.00</b>
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> <p>Capital Health <b>RECEIVED</b> AUG 04 2006 ACCOUNTS PAYABLE</p> </div>						
<input checked="" type="checkbox"/> Canadian	<input type="checkbox"/> U.S.	<input type="checkbox"/> Other	<b>TOTAL</b>	<b>\$830.00</b>		<b>NT</b> \$830.00
<b>IV AUTHORIZATION</b>						
I confirm that the above items have not been previously paid and the expenses related only to Capital Health business.						
Requisitioned by (Print name) <b>Aileen Savage</b>			Phone # <b>735-5272</b>			
(Signature) <i>Aileen Savage</i>			Date <b>2-Aug-06</b>			
Approved by (Print name) <b>Glenda Coleman-Miller</b>			Phone # <b>735-5271</b>			
(Signature) <i>G. Coleman-Miller</i>			Date <b>2-Aug-06</b>			
Approved by (Print name) <b>Joanna Pawlyshyn</b>			Phone # <b>735-4101</b>			
(Signature) <i>Joanna Pawlyshyn</i>			Date			
			<b>LOIS STEFANIVIC FOR (See Attached)</b>			
			<i>Lois Stefaniwic for</i>			
<b>AUTHORIZATIONS SHOULD BE IN ACCORDANCE WITH SIGNING AUTHORITY POLICY NUMBER FINANCE 4.1</b>						
Notes:						
1) All employee payments will be made electronically based on payroll banking information.						
2) All cheques and attachments will be mailed out by Accounting Services. Cheques will NOT be pulled and returned to departments for mailing.						
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4) <b>Incomplete/improperly authorized payment requisitions will be returned without processing</b>						

APPLICANT COPY



**Halifax 6: The Canadian Healthcare Safety Symposium**  
 October 19 to 21, 2006  
 Vancouver, British Columbia

BUKSA ASSOCIATES  
 SUITE 307, 10328-81 AVE  
 EDMONTON, AB  
 T6E 1X2  
 s.17(1), 17(4)(e.1)

Canadian Healthcare Safety Symposium  
 Registrations

CARD  
 CARD TYPE VISA  
 DATE 2006/06/20  
 TIME 0918 10:03:30  
 RECEIPT NUMBER  
 M34537598-001-084-041-0

**RECEIPT**  
 The Canadian Healthcare Safety Symposium  
 GST # 81157 7345 RT0001

Date	Receipt No.
06/20/2006	H000141

PURCHASE  
 TOTAL-CAD  
**\$830.00**

**Payer:**

Glenda Coleman-Miller  
 10240 Kingsway  
 Edmonton, AB T5H 3V9

**APPROVED**

AUTH# 012672 01-027  
 THANK YOU

CARDHOLDER COPY

Inv No.	Description	Total Fees	Tax	Applied Amount
H0000231	Registration for Glenda Coleman-Miller for the event: <i>Halifax 6: The Canadian Healthcare Safety Symposium</i>	\$630.00		\$630.00
H0000231	Registration for Glenda Coleman-Miller for the event: <i>Advances in Education and Team Training for Healthcare</i>	\$200.00		\$200.00

<b>GST = \$0.00</b>		<b>Total Fees w/Tax</b>	<b>\$830.00</b>
Visa:		<b>Total Paid</b>	<b>\$830.00</b>
s.17(1), 17(4)(g)(i)		<b>Total Applied</b>	<b>\$830.00</b>
		<b>Unapplied Balance</b>	<b>0.00</b>

Thank you for your payment received on 06/20/2006.

Note: If you paid by credit card, your statement will read **BUKSA Assoc. (780) 436-0983 Edm.**

**Halifax 6: The Canadian Healthcare Safety Symposium**  
 c/o BUKSA Conference Management and Program Development  
 Suite 307, 10328 - 81 Avenue NW Edmonton AB T6E 1X2  
 Phone: (780) 436-0983 ext. 231 Fax: (780) 437-5984 E-mail: halifax@buksa.com



# APPLICANT COPY

Accounting Services  
10<sup>th</sup> Floor, North Tower CHC  
19030-107 St.  
Edmonton, Alberta T5J 3E4

## Payment Requisition

**I PAYEE INFORMATION** (Check one only)     Vendor     Patient     Employee (EE number)

Invoice Date <b>5-Sep-06</b> (DD-MMM-YY)	Invoice Number	s.17(1), 17(4)(g)(i)
Vendor Number (or S.I.N.)	Payee Name <b>Glenda Coleman-Miller</b>	
Address:	s.17(1), 17(4)(g)(i)	City
Province/State	Postal Code	Country

**II PAYMENT DETAILS**

Reason for payment: **Re-Imbursement for Registration Costs for KATHY Lambert, Diana Gorok, Diane Anderson - CAMIS**    PO #

Is this a contract payment?     Yes (Attach copy of contract if not previously forwarded)     No

If this is a contract payment, what is the contract date?    Number

Have goods / services been received?     Yes, When?     No

Are original attachments to be mailed with cheque? (Note 2)     Yes     No

**III EXPENSE CODES (IN ORACLE FINANCIAL SYSTEM FORMAT)** (Departments must provide Complete Coding)

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Expense Sub-Total	GST if applicable	Total Payment
201	0002	71110101001	61030000	\$429.30		\$429.30
<input type="checkbox"/> Canadian	<input type="checkbox"/> U.S.	<input type="checkbox"/> Other	<b>TOTAL</b>	<b>\$429.30</b>		<b>\$429.30</b>

**IV AUTHORIZATION**

I confirm that the above items have not been previously paid and the expenses related only to Capital Health business.

Requisitioned by (Print name) **Aileen Savage**    Phone # **735-5272**

(Signature) *Aileen Savage*    Date **5-Sep-06**

Approved by (Print name) **Glenda Coleman-Miller**    Phone # **735-5271**

(Signature) *Glenda Coleman-Miller*    Date **5-Sep-06**

Approved by (Print name) **Joanna Pawlyshyn**    Phone # **735-4101**

(Signature) *Joanna Pawlyshyn*    Date **05 Sept 06**

**AUTHORIZATIONS SHOULD BE IN ACCORDANCE WITH SIGNING AUTHORITY POLICY NUMBER FINANCE 4.1**

Notes:

- All employee payments will be made electronically based on payroll banking information.
- All cheques and attachments will be mailed out by Accounting Services. Cheques will NOT be pulled and returned to departments for mailing.
- Fully completed payment requisitions received in Accounting Services by **MONDAY, 4:00 p.m.** will be processed that week.
- Incomplete/improperly authorized payment requisitions will be returned without processing**



**Account Details**

September 05, 2006 at 11:27am Eastern tin

Account Type:	CIBC VISA	Statement Date*:	Aug. 27, 2006
Account Number:		Statement Balance*:	Non-Responsive
Available Credit:		Minimum Payment Due*:	Non-Responsive
Balance Owing:		Payment Due Date*:	Sep. 16, 2006
Last Payment:			Non-Responsive
Payment to be Processed:	\$0.00		

Account Details — Aug. 06, 2006 to Sep. 05, 2006

<u>Transaction Date</u>	<u>Posted Date</u>	<u>Transaction Details</u>	Non-Responsive	<u>Debit</u>	<u>Credit</u>
Aug. 09, 2006	Aug. 10, 2006	CONFERENCE/TRADESHOW REGIMISSISSAUGA ON		\$159.00	
Aug. 09, 2006	Aug. 10, 2006	CONFERENCE/TRADESHOW REGIMISSISSAUGA ON		\$159.00	
Aug. 09, 2006	Aug. 10, 2006	CONFERENCE/TRADESHOW REGIMISSISSAUGA ON		\$111.30	
					<u>Non-Responsive</u>

CI-9.1



APPLICANT COPY

Canadian Surgery  
**forum**  
canadien de chirurgie

# Registration Form

September 7-10  
du 7 au 10 septembre **Calgary 2006**

Canadian Surgery Forum  
Attn: Registration  
c/o Exposoft Solutions Inc.  
2145 Meadowpine Blvd  
Mississauga, ON L5N 6R8  
Facsimile: 1-888-745-8757  
Telephone for information only: 613-260-4175

If you register by facsimile, please do not also mail your form.

### A BADGE SELECTION

Dr.     Mr.     Ms.  
 Given Name Diane    Family Name Goruk  
 Institution Royal Alexandra Hospital (as it will appear on badge)  
 Address Room 3003-1  
10240 Kingsway  
 City Edmonton    Province/State Alberta  
 Postal/Zip Code T5H 3V9    Country Canada  
 Telephone 780-735-5010  
 Facsimile 780-735-4388  
 E-mail dgoruk@cha.ab.ca

Facsimile  
 Mail  
 E-mail

The data provided could be disclosed for commercial purposes or membership recruitment. Please check box if you do not wish to have your name disclosed.

Emergency Contact Information: Name: \_\_\_\_\_ s.17(1), 17(4)(g)(i)  
 Relationship: \_\_\_\_\_ Telephone: \_\_\_\_\_

### B BADGE SELECTION

Please check one category:

Member Participating Society\*     Resident  
 Non-Member     Student

Enter the numbers of up to three Participating Societies of which you are a member.

Code # \_\_\_\_\_  
 Membership # \_\_\_\_\_

**Participating Societies:**

- 835 Alberta Association of General Surgeons (AAGS)
- 315 Canadian Association of General Surgeons (CAGS)
- 465 Canadian Association of Paediatric Surgeons (CAPS)
- 480 Canadian Association of Thoracic Surgeons (CATS)
- 043 Canadian Association of Surgical Chairmen (CASC)
- 825 Canadian Association of University Surgeons (CAUS)
- 512 Canadian Society of Colon and Rectal Surgeons (CSCRS)
- 811 Canadian Society of Surgical Oncology (CSSO)
- 046 Canadian Undergraduate Surgical Education Committee (CUSEC)
- 040 James IV Association of Surgeons (James IV)
- 810 Trauma Association of Canada (TAC)

### C FORUM REGISTRATION FEES

Please one category:

	Rec. by/on Aug. 11	On-Site	One-day Fee*
<input type="checkbox"/> Member	350.00+GST=\$374.50	425.00+GST=\$454.75	245.00+GST=\$262.15
<input type="checkbox"/> Non-Member	450.00+GST=\$481.50	550.00+GST=\$588.50	315.00+GST=\$337.05
<input type="checkbox"/> Resident**	150.00+GST=\$160.50	200.00+GST=\$214.00	105.00+GST=\$112.35
<input type="checkbox"/> Student**	150.00+GST=\$160.50	200.00+GST=\$214.00	105.00+GST=\$112.35
<input checked="" type="checkbox"/> Nurse**	150.00+GST=\$160.50	200.00+GST=\$214.00	105.00+GST=\$112.35

\*please specify day: 148  
 \*\*with letter from program director or chairman of department

TOTAL REGISTRATION FEE: \$ \_\_\_\_\_  
 (Transfer to SECTION J)

go to SECTION D

Pre-registration Deadline: Friday, August 11, 2006

### J PAYMENT

Forum Registration Fee: (see page 1)  
 Postgraduate Course Fee: (see page 2)  
 Breakfast with the Professor Fee: (see page 2)  
 Self-Assessment Exam Fee: (see page 2)  
 CSF Dinner/CAPS Banquet Tickets: (see page 2)

Total - SECTION C \$ \_\_\_\_\_  
 Total - SECTION D \$ \_\_\_\_\_  
 Total - SECTION E \$ \_\_\_\_\_  
 Total - SECTION G \$ \_\_\_\_\_  
 Total - SECTION H \$ \_\_\_\_\_  
 Total \$ \_\_\_\_\_

Payment enclosed:  Cash     Cheque (payable to Canadian Surgery Forum)  
 VISA     MasterCard     American Express

Credit card number \_\_\_\_\_ Expiry date \_\_\_\_\_  
 Cardholder signature Suleman-Miller

s.17(1), 17(4)(e.1)

Your payment will appear on your credit card statement as a payment to the CONFERENCE TRADE SHOW REGISTRATION.  
 GST Registration No.: 106 842 727



SEARCH (F7):

LastName

Payments

SEARCH PREVIOUS ADD REPORTS ADMIN DATA HELP Data table: RegData CSF2006

LOG OUT

RECORD ITEMS ADD ITEMS PAYMENTS STATMNT EMAIL BADGE PRINT HISTORY

ID	FIRSTNAME	LASTNAME	STATUS
1466	DIANE	GORUK	REGISTERED

INVOICEABLE ITEMS:

EDIT	DATE	QTY	DESCRIPTION	AMOUNT	DISCOUNT	TAX1	TAX2	SUBTOTAL
X	8/9/2006	1	Nurse **	150.00	0.00	6.0%	0.0%	159.00
TOTAL								150.00
TAX1								9.00
TAX2								0.00
TOTAL FEES								159.00
PAYMENTS								159.00
BALANCE (CDN\$)								\$0.00

PAYMENT HISTORY:

ID	DESC	AMOUNT	METHOD	AUTH#	NOTES	USERNAME	DATE/TIME	STATUS
227661	payment	\$159.00	CC	036596		Kevin Tomlinson	8/9/2006-11:56	ACCEPTED

ENTER NEW PAYMENT / CREDIT:

DESCRIPTION	AMOUNT	METHOD	NOTES/REFERENCE	CASHIER ID
	0.00	CC		

PROCESS PAYMENT / NEXT (F12)

© 1997 - 2006 Copyright - Exposoft Solutions Inc - Version 5.2.15  
 Best viewed with minimum Internet Explorer v5.5 in 1024x768 resolution (min).  
 dictSession(UserName): Canadian Surgery Staff  
 gintUserID: 42  
 gintTableID: 42  
 Timer: 78





SEARCH (F7):  
 LastName

Payments

SEARCH PREVIOUS ADD REPORTS ADMIN DATA HELP Data table: RegData  
 CSF2006 LOG OUT

RECORD ITEMS ADD ITEMS PAYMENTS STATEMENT EMAIL BADGE PRINT HISTORY

ID	FIRSTNAME	LASTNAME	STATUS
1464	KATHY	LAMBERT	REGISTERED

INVOICEABLE ITEMS:

EDIT	DATE	QTY	DESCRIPTION	AMOUNT	DISCOUNT	TAX1	TAX2	SUBTOTAL
X	8/9/2006	1	Nurse **	150.00	0.00	6.0%	0.0%	159.00
TOTAL								150.00
TAX1								9.00
TAX2								0.00
TOTAL FEES								159.00
PAYMENTS								159.00
BALANCE (CDN\$)								\$0.00

PAYMENT HISTORY:

ID	DESC	AMOUNT	METHOD	AUTH#	NOTES	USERNAME	DATE/TIME	STATUS
227658	payment	\$159.00	CC	006219		Kevin Tomlinson	8/9/2006-11:41	ACCEPTED

ENTER NEW PAYMENT / CREDIT:

DESCRIPTION	AMOUNT	METHOD	NOTES/REFERENCE	CASHIER ID
<input type="text"/>	0.00	CC	<input type="text"/>	<input type="text"/>

PROCESS PAYMENT / NEXT (F12)

© 1997 - 2006 Copyright - Exposoft Solutions Inc - Version 5.2.15  
 Best viewed with minimum Internet Explorer v5.5 in 1024x768 resolution (min).  
 dictSession(UserName): Canadian Surgery Staff  
 gintUserID: 42  
 gintTableID: 42  
 Timer: 94





register online at  
www.surgeryforum.ca



# Registration Form

Canadian Surgery Forum

Attn: Registration  
c/o Exposoft Solutions Inc.  
2145 Meadowpine Blvd  
Mississauga, ON L5N 6R8  
Facsimile: 1-888-745-8757

Telephone for information only: 613-260-4175

September 7-10  
du 7 au 10 septembre

## Calgary 2006

If you register by facsimile, please do not also mail your form.

### A BADGE SELECTION

Dr.  Mr.  Ms

Given Name KATHY LAMBERT Family Name LAMBERT

Institution RAH (ROYAL ALEX HOSP)  
(as it will appear on badge)

Address RR#2 SITE 645 CUMP-5

City ST. ALBERT Province/State AB

Postal/Zip Code T8N1M9 Country CANADA

Telephone 418-7732  
s.17(1), 17(4)(g)(i)

Facsimile \_\_\_\_\_

E-mail \_\_\_\_\_

Please indicate how you would like to receive your confirmation of registration:

Facsimile  
 Mail  
 E-mail

The data provided could be disclosed for commercial purposes or membership recruitment. Please check box if you do not wish to have your name disclosed.

#### Emergency Contact Information

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Telephone: \_\_\_\_\_

### B BADGE SELECTION

Please check one category:

Member Participating Society\*  Resident  
 Non-Member  Student

Enter the numbers of up to three Participating Societies of which you are a member.

Code # \_\_\_\_\_

Membership # \_\_\_\_\_

#### Participating Societies:

- 835 Alberta Association of General Surgeons (AAGS)
- 315 Canadian Association of General Surgeons (CAGS)
- 465 Canadian Association of Paediatric Surgeons (CAPS)
- 480 Canadian Association of Thoracic Surgeons (CATS)
- 043 Canadian Association of Surgical Chairmen (CASC)
- 825 Canadian Association of University Surgeons (CAUS)
- 512 Canadian Society of Colon and Rectal Surgeons (CSCRS)
- 811 Canadian Society of Surgical Oncology (CSSO)
- 046 Canadian Undergraduate Surgical Education Committee (CUSEC)
- 040 James IV Association of Surgeons (James IV)
- 810 Trauma Association of Canada (TAC)

### C FORUM REGISTRATION FEES

Please one category:

	Rec. by/on Aug. 11	On-Site	One-day Fee*
<input type="checkbox"/> Member	350.00+GST=\$374.50	425.00+GST=\$454.75	245.00+GST=\$262.15
<input type="checkbox"/> Non-Member	450.00+GST=\$481.50	550.00+GST=\$588.50	315.00+GST=\$337.05
<input type="checkbox"/> Resident**	150.00+GST=\$160.50	200.00+GST=\$214.00	105.00+GST=\$112.35
<input type="checkbox"/> Student**	150.00+GST=\$160.50	200.00+GST=\$214.00	105.00+GST=\$112.35
<input checked="" type="checkbox"/> Nurse**	150.00+GST=\$160.50	200.00+GST=\$214.00	105.00+GST=\$112.35

\*please specify day: 748

\*\*with letter from program director or chairman of department

TOTAL REGISTRATION FEE: \$ \_\_\_\_\_  
(Transfer to SECTION J)

go to SECTION D

Pre-registration Deadline: Friday, August 11, 2006

### J PAYMENT

- Forum Registration Fee: (see page 1)
- Postgraduate Course Fee: (see page 2)
- Breakfast with the Professor Fee: (see page 2)
- Self-Assessment Exam Fee: (see page 2)
- CSF Dinner/CAPS Banquet Tickets: (see page 2)

s.17(1), 17(4)(e.1)

Payment enclosed:  Cash  Cheque (payable to Canadian Surgery Forum)  
 VISA  MasterCard  American Express

Credit card number: \_\_\_\_\_ Expiry date: \_\_\_\_\_

Cardholder signature: [Signature]

Total - SECTION C	\$ _____
Total - SECTION D	\$ _____
Total - SECTION E	\$ _____
Total - SECTION G	\$ _____
Total - SECTION H	\$ _____
Total	\$ _____

Your payment will appear on your credit card statement as a payment to the CONFERENCE

TRADE SHOW REGISTRATION.

GST Registration No.: 106 842 727



SEARCH (F7):  
 LastName

Payments

SEARCH PREVIOUS + ADD REPORTS ADMIN DATA HELP Data table: RegData  
 CSF2006

LOG OUT

RECORD ITEMS ADD ITEMS PAYMNTS STATMNT EMAIL BADGE PRINT HISTORY

ID	FIRSTNAME	LASTNAME	STATUS
1462	ELAINE	MCHUGH	REGISTERED

ELAINE ANDERSON

INVOICEABLE ITEMS:

EDIT	DATE	QTY	DESCRIPTION	AMOUNT	DISCOUNT	TAX1	TAX2	SUBTOTAL
<input checked="" type="checkbox"/>	8/9/2006	1	Nurse **	105.00	0.00	6.0%	0.0%	111.30
TOTAL								105.00
TAX1								6.30
TAX2								0.00
TOTAL FEES								111.30
PAYMENTS								111.30
BALANCE (CDN\$)								\$0.00

PAYMENT HISTORY:

ID	DESC	AMOUNT	METHOD	AUTH#	NOTES	USERNAME	DATE/TIME	STATUS
227653	payment	\$111.30	CC	065715		Kevin Tomlinson	8/9/2006-11:23	ACCEPTED

ENTER NEW PAYMENT / CREDIT:

DESCRIPTION	AMOUNT	METHOD	NOTES/REFERENCE	CASHIER ID
	0.00	CC		

PROCESS PAYMENT / NEXT (F12)

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 Best viewed with minimum Internet Explorer v5.5 in 1024x768 resolution (min).  
 dictSession(Username): Canadian Surgery Staff  
 gintUserID: 42  
 gintTableID: 42  
 Timer: 109





# Registration Form

September 7-10  
du 7 au 10 septembre

## Calgary 2006

Canadian Surgery Forum  
Attn: Registration  
c/o Exposoft Solutions Inc.  
2145 Meadowpine Blvd  
Mississauga, ON L5N 6R8  
Facsimile: 1-888-745-8757

Telephone for information only: 613-260-4175

If you register by facsimile, please do not also mail your form.

### A BADGE SELECTION

Dr.     Mr.     Ms

s.17(1), 17(4)(g)(i)

Given Name Diane Family Name Anderson

Institution Royal Alexandra Hospital  
(as it will appear on badge)

Address \_\_\_\_\_

City \_\_\_\_\_

Province/State \_\_\_\_\_

Postal/Zip Code \_\_\_\_\_

Country Canada

Telephone (780) 464-1168

Facsimile \_\_\_\_\_

E-mail \_\_\_\_\_

Please indicate how you would like to receive your confirmation of registration:

Facsimile  
 Mail  
 E-mail

The data provided could be disclosed for commercial purposes or membership recruitment. Please check box if you do **not** wish to have your name disclosed.

#### Emergency Contact Information

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

Relationship: \_\_\_\_\_

Telephone: \_\_\_\_\_

### B BADGE SELECTION

Please check one category:

Member Participating Society\*     Resident  
 Non-Member     Student

Enter the numbers of up to three Participating Societies of which you are a member.

Code # \_\_\_\_\_

Membership # \_\_\_\_\_

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Please one category:

	Rec. by/on Aug. 11	On-Site	One-day Fee*
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<input type="checkbox"/> Non-Member	450.00+GST=\$481.50	550.00+GST=\$588.50	315.00+GST=\$337.05
<input type="checkbox"/> Resident**	150.00+GST=\$160.50	200.00+GST=\$214.00	105.00+GST=\$112.35
<input type="checkbox"/> Student**	150.00+GST=\$160.50	200.00+GST=\$214.00	105.00+GST=\$112.35
<input checked="" type="checkbox"/> Nurse**	150.00+GST=\$160.50	200.00+GST=\$214.00	105.00+GST=\$112.35

\*please specify day: 1, 8 Sept '06

\*\*with letter from program director or chairman of department

TOTAL REGISTRATION FEE: \$ \_\_\_\_\_

(Transfer to SECTION J)

go to SECTION D

Pre-registration Deadline: Friday, August 11, 2006

### J PAYMENT

Forum Registration Fee: (see page 1)

Postgraduate Course Fee: (see page 2)

Breakfast with the Professor Fee: (see page 2)

Self-Assessment Exam Fee: (see page 2)

CSF Dinner/CAPS Banquet Tickets: (see page 2)

Payment enclosed:  Cash     Cheque (payable to Canadian Surgery Forum)  
 VISA     MasterCard     American Express

Credit card number \_\_\_\_\_ Expiry date \_\_\_\_\_

Cardholder signature \_\_\_\_\_

Total - SECTION C    \$ \_\_\_\_\_  
Total - SECTION D    \$ \_\_\_\_\_  
Total - SECTION E    \$ \_\_\_\_\_  
Total - SECTION G    \$ \_\_\_\_\_  
Total - SECTION H    \$ \_\_\_\_\_  
Total    \$ \_\_\_\_\_

Your payment will appear on your credit card statement as a payment to the CONFERENCE

TRADE SHOW REGISTRATION.

GST Registration No.: 106 842 727



# APPLICANT COPY

Accounting Services  
10<sup>th</sup> Floor, North Tower CHC  
10030-107 St.  
Edmonton, Alberta T5J 3E4

## Payment Requisition s.17(1), 17(4)(g)(i)

**I PAYEE INFORMATION** (Check one only)     Vendor     Patient     Employee

Invoice Date **1-Aug-06** (DD-MMM-YY)    Invoice Number **103814 REIMBURSE-01AUG06**

Vendor Number (or S.I.N.)    Payee Name **Glenda Coleman-Miller**

Address    s.17(1), 17(4)(g)(i)    City

Province/State    Postal Code    Country

### II PAYMENT DETAILS

Reason for payment **Re-imburement for Lois Hole Fundraiser - What a Girl Wants**    PO #

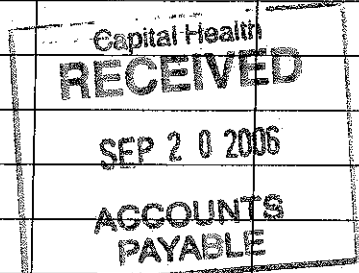
Is this a contract payment?     Yes (Attach copy of contract if not previously forwarded)     No

If this is a contract payment, what is the contract date?    Number

Have goods / services been received?     Yes, When?     No

Are original attachments to be mailed with cheque? (Note 2)     Yes     No

### III EXPENSE CODES (IN ORACLE FINANCIAL SYSTEM FORMAT) (Departments must provide Complete Coding)

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Expense Sub-Total	GST if applicable	Total Payment
201	0002	71110101001	6950000	\$175.00		\$175.00
						(T) \$175.00
<input checked="" type="checkbox"/> Canadian <input type="checkbox"/> U.S. <input type="checkbox"/> Other			TOTAL	\$175.00		

### IV AUTHORIZATION

I confirm that the above items have not been previously paid and the expenses related only to Capital Health business.

Requisitioned by (Print name) **Aileen Savage**    Phone # **735-5272**

(Signature) *Aileen Savage*    Date **13-Sep-06**

Approved by (Print name) **Glenda Coleman-Miller**    Phone # **735-5271**

(Signature) *Glenda Coleman-Miller*    Date **14-Sep-06**

Approved by (Print name) **Joanna Pawlyshyn**    Phone # **735-4101**

(Signature) *Joanna Pawlyshyn*    Date **18 Sep 06**

**AUTHORIZATIONS SHOULD BE IN ACCORDANCE WITH SIGNING AUTHORITY POLICY NUMBER FINANCE 4.1**

Notes:

- 1) All employee payments will be made electronically based on payroll banking information.
- 2) All cheques and attachments will be mailed out by Accounting Services. Cheques will **NOT** be pulled and returned to departments for mailing.
- 3) Fully completed payment requisitions received in Accounting Services by **MONDAY, 4:00 p.m.** will be processed that week.
- 4) **Incomplete/improperly authorized payment requisitions will be returned without processing**

<b>R</b> Received from Recu de	Date	08/07/06	103814
		Glenda Coleman-Miller	
		What A Girl Wants	100 Dollars
\$	175.00	ticket # 135	
<small>© Buellner</small>			



APPLICANT COPY

Travel & Employee Expense Claim Form

(In Canadian Dollars)

s.17(1), 17(4)(g)(i)

Name: Glenda Coleman-Miller	Employee Number:	Union Name:
Position: Senior Operating Officer	Department: RAH - EXEC	
Business Phone: 735-5271	Period From: July to September 2006	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0002	71110101001	62410000			\$121.90	<input type="checkbox"/>
201	0002	71110101001	62410000			105.90 <sup>55</sup>	<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
Total						(T) \$227.80 <sup>45</sup>	<input type="checkbox"/>

Capital Health  
**RECEIVED**  
OCT 06 2006  
**ACCOUNTS  
PAYABLE**

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: *Glenda Coleman-Miller* Date: September 29, 2006

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: Joanna Pawlyshyn (Print name)	Title: V.P. & C.O.O.	Phone # 735-4101
(Signature) <i>[Signature]</i>	010206	Date
Approved By:	Title:	Phone #
(Signature)		Date

NOTE:

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
- GST amounts included in the expense claims will be calculated by Accounts Payable.
- Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
- For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
- For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
- See page 2 of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

*[Handwritten mark]*

**APPLICANT COPY**  
**EXPENSE CLAIM DETAILS**

Recommended Coding								
<ul style="list-style-type: none"> <li>Local Travel – Staff - 62410000</li> <li>Staff Local Travel – Taxi – 62410001</li> <li>Staff Travel – UNA – 62410002</li> <li>Staff Provincial Travel – 62412000 (all expenses)</li> <li>Staff Out of Province Travel – 62414000 (all expenses)</li> </ul>				<ul style="list-style-type: none"> <li>Catering – 69600000</li> <li>Meals - 62410000</li> <li>Mileage – 62410000</li> <li>Course Registration &amp; Materials – 61030000</li> </ul>				
Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km	
July 2006	Business Travel - Local				✓ \$8.00		24	
Aug. 2006	Business Travel - Loca				✓ 51.50	15	128	
Sept. 2006	Business Travel - Loca				✓ 46.40		131.5	
							<b>Total km</b>	283
							<b>Rate as outlined in Section 2 – Travel below @</b>	0.43
<b>Totals</b>					<del>\$105.90</del>		\$121.90	

105.55

**EXPENSE LIMITS**

**1. Meal Allowances**

When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:

- Breakfast \$8.50 (if the departure time is earlier or the return time is later than 7:30 a.m.)
- Lunch \$10.75 (if the departure time is earlier or the return time is later than 1:00 p.m.)
- Dinner \$19.20 (if the departure time is earlier or the return time is later than 6:30 p.m.)

For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.

Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.

**2. Travel**

- Use of personal automobile – From March 1, 2006, reimbursement at the general rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
- Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
- Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
  1. Monthly travel in excess of 340 kilometers; or
  2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
  3. Daily requirements to utilize personal vehicle in the course of duties -- reimbursed at \$0.50 per kilometer.
- If union contract rate differs from \$0.43 then contract rate must be used.
- Includes all forms of transportation costs, including taxis and buses for local travel.
- Driving to and from work is not considered business travel and cannot be claimed.

**3. Advance**

Travel advance may be requested provided travel expenses are likely to exceed \$500.

APPLICANT COPY



Capital Health

MILEAGE AND PARKING CLAIM FORM (WITHIN REGION)

Program	Employee Name	Location	Payroll #
---------	---------------	----------	-----------

NOTE: 1) It is the employee's responsibility to maintain adequate records to substantiate all mileage claims to Revenue Canada, Program Management, or Finance upon request. You must be able to provide documentation which shows the date, destination and km travelled on each of your trips.  
 2) Driving to and from work is not considered business travel and must not be claimed.

Month <i>July</i>	Year <i>2006</i>
----------------------	---------------------

Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	Date	KM	Parking
1			9			17			25		
2			10			18			26		
3			11			19	<i>8</i>	<i>8.00</i>	27		
4			12			20			28		
5			13			21	<i>16</i>		29		
6			14			22			30		
7			15			23			31		
8			16			24					

Total	<i>24</i>	<i>8.00</i>
-------	-----------	-------------

Declaration: I hereby certify that the mileage and parking charges listed above were incurred on Capital Health business and that the amount has not been previously claimed by me or on my behalf.



<b>DISPLAY FACE UP ON DASH RECEIPT</b>	
<b>Impark Lot 002-256</b>	
EDMONTON, AB.	
GST #88731 5638 RT0001	
Machine Serial #:000005071052	
<b>EXPIRY DATE AND TIME</b>	
<b>EXP 12:00pm</b>	EXP 12:00pm
<b>JUL 19,2006</b>	JUL 19,2006
<b>TICKET#</b>	<b>LOT#</b>
<b>00013277</b>	<b>00020256</b>
C \$0008.00	MACH# 001
FOLLOW INSTRUCTIONS ON SIGNS POSTED	
<b>Park 2 Hr. \$8.00</b>	
<b>Questions/Comments?</b>	
<b>Call 780-420-1976</b>	
<b>DISPLAY FACE UP ON DASH RECEIPT</b>	

APPLICANT COPY



MILEAGE AND PARKING CLAIM FORM (WITHIN REGION)

Program <i>EXEC</i>	Employee Name <i>Glenda Coleman-Miller</i>	Location <i>RAH</i>	Payroll #
------------------------	---	------------------------	-----------

s:17(1), 17(4)(g)(i)

NOTE: 1) It is the employee's responsibility to maintain adequate records to substantiate all mileage claims to Revenue Canada, Program Management, or Finance upon request. You must be able to provide documentation which shows the date, destination and km travelled on each of your trips.  
2) Driving to and from work is not considered business travel and must not be claimed.

Month <i>August</i>	Year <i>2006</i>
------------------------	---------------------

Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	
1	16	4.50	9			17			25	16		
2			10			18			26			
3	16	4.50	11			19			27			
4			12			20			28			
5			13			21			29			
6			14			22			30	32	14.40	
7			15	16	10.50	23			31	16	10.50	
8			16	16	6.75	24						
										Total	128	51.15

Declaration: I hereby certify that the mileage and parking charges listed above were incurred on Capital Health business and that the amount has not been previously claimed by me or on my behalf.

ON DASH RECEIPT

Impark Lot 002-256

EDMONTON, AB.  
GST #88731 5638 RT0001  
Machine Serial #:00005071052

EXPIRY DATE AND TIME

**EXP 03:22pm**  
**AUG 15, 2006**

TICKET# LOT#  
00015792 00020256

CC: \$0006.00 Visa MACH# 001

FOLLOW INSTRUCTIONS ON SIGNS POSTED  
s.17(1), 17(4)(e.1)

Park 1 1/2 Hr \$6.00

Questions/Comments?  
Call 780-420-1976

ON DASH RECEIPT

EXP 03:22pm  
AUG 15, 2006

TIC# 00015792  
MACH# 001

CC: \$0006.00  
AUG15,2006

01:52pm  
Purchase Time

s.17(1), 17(4)(e.1)

APPLICANT COPY

SOUTH HALL  
UNIVERSITY HOSPITAL, MEDICAL PARKING

SOUTH HALL  
UNIVERSITY HOSPITAL, MEDICAL PARKING

UNIVERSITY OF ALBERTA  
HOSPITAL 114 ST.  
THANK YOU FOR PARKING

UNIVERSITY OF ALBERTA  
HOSPITAL 114 ST.  
THANK YOU FOR PARKING

Best Copy Possible

Best Copy Possible

09/24/06 14:43 LH 1 AM 2 TXM037550  
09/16/06 14:42 IN 09/16/06 14:43 OUT  
TR# 597623  
DAILY RATE \$ 6.75  
TOTAL FEE \$ 6.75  
CASH PAID \$ 6.75  
CASH TENDER \$ 0.00  
CHANGE DUE \$ 0.00

09/21/06 14:43 LH 1 AM 2 TXM037550  
09/16/06 14:42 IN 09/16/06 14:43 OUT  
TR# 597623  
DAILY RATE \$ 6.40  
TOTAL FEE \$ 6.40  
CASH PAID \$ 6.40  
CASH TENDER \$ 0.00  
CHANGE DUE \$ 0.00

ROPER 31354  
09/30/06 09:43 LH 1 AM 2 TXM043363  
09/30/06 07:03 IN 09/30/06 09:43 OUT  
TR# 594881  
DAILY RATE \$ 9.00  
TOTAL FEE \$ 9.00  
CASH PAID \$ 9.00  
CASH TENDER \$ 10.00  
CHANGE DUE \$ 1.00

ROPER 31354  
09/31/06 11:09 LH 1 AM 2 TXM044137  
09/31/06 07:43 IN 09/31/06 11:09 OUT  
TR# 597650  
DAILY RATE \$ 10.50  
TOTAL FEE \$ 10.50  
CASH PAID \$ 10.50  
CASH TENDER \$ 10.50  
CHANGE DUE \$ 0.00

APPLICANT COPY

APPLICANT COPY



**MILEAGE AND PARKING CLAIM FORM (WITHIN REGION)**

Program <i>EXEC</i>	Employee Name <i>Glenda Coleman-Miller</i>	Location <i>RAH</i>	Payroll #
------------------------	---	------------------------	-----------

NOTE: 1) It is the employee's responsibility to maintain adequate records to substantiate all mileage claims to Revenue Canada, Program Management, or Finance upon request. You must be able to provide documentation which shows the date, destination and km travelled on each of your trips. s.17(1), 17(4)(g)(i)

2) Driving to and from work is not considered business travel and must not be claimed.

Month <i>Sept</i>	Year <i>2006</i>
----------------------	---------------------

Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	Date	KM	Parking			
1			9			17			25	<i>32</i>	<i>19.50</i>			
2			10			18			26	<i>26</i>	<i>4.50</i>			
3			11	<i>16</i>	<i>4.50</i>	19			27	<i>9.5</i>	<i>8.00</i>			
4			12			20			28					
5			13			21	<i>16</i>	<i>5.40</i>	29					
6			14			22			30					
7	<i>16</i>	<i>4.50</i>	15			23			31					
8	<i>16</i>		16			24			<table border="1"> <tr> <td>Total</td> <td><i>131.5</i></td> <td><i>46.40</i></td> </tr> </table>			Total	<i>131.5</i>	<i>46.40</i>
Total	<i>131.5</i>	<i>46.40</i>												

Declaration: I hereby certify that the mileage and parking charges listed above were incurred on Capital Health business and that the amount has not been previously claimed by me or on my behalf.



DATE 09/21/06

LOT 257 UAH

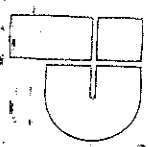
TICKET No. 577-893

AMOUNT 5.40

SIGNATURE [Signature]

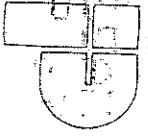
G.S.T. #88731 5638 RT0001 IM-003

APPLICANT COPY



impark

PLACE THIS SIDE UP ON DASH



impark

PLACE THIS SIDE UP ON T

TICKET VOID IF RE-SOLD

TICKET VOID IF RE-SOLD

UNIVERSITY OF ALABAMA  
ALABAMA STATE COLLEGE  
TICKET VOID IF RE-SOLD

Best Copy Possible

Event 4238  
09/26/06 11:00 PM 11:00 PM  
09/26/06 11:00 PM 09/26/06 11:00 PM  
Total FEE \$ 4.00  
Cash Paid \$ 4.00  
Event Date \$ 0.00

UNIVERSITY OF ALABAMA  
ALABAMA STATE COLLEGE  
TICKET VOID IF RE-SOLD

Best Copy Possible

Event 4238  
09/26/06 11:00 PM 11:00 PM  
09/26/06 11:00 PM 09/26/06 11:00 PM  
Total FEE \$ 12.00  
Cash Paid \$ 12.00  
Event Date \$ 0.00

UNIVERSITY OF ALABAMA  
ALABAMA STATE COLLEGE  
TICKET VOID IF RE-SOLD

Best Copy Possible

Event 4238  
09/26/06 11:00 PM 11:00 PM  
09/26/06 11:00 PM 09/26/06 11:00 PM  
Total FEE \$ 7.00  
Cash Paid \$ 7.00  
Event Date \$ 0.00

APPLICANT COPY

UNIVERSITY OF ALBERTA  
HOSPITAL 114 St.  
THANK YOU FOR PARKING

Best Copy Possible

RD# 21090  
09/07/06 19:49 L# 1 M 3 TRN:5040  
09/07/06 16:40 in 09/07/06 19:19 out  
TRN 56201  
Daily Rate \$ 4.50  
Total Fee \$ 4.50  
Cash Paid \$ 4.50  
Cash Tender \$ 5.00  
Change Due \$ 0.50

UNIVERSITY OF ALBERTA  
HOSPITAL 114 St.  
THANK YOU FOR PARKING

Best Copy Possible

RD# 3570  
09/11/06 17:14 L# 1 M 3 TRN:5043  
09/11/06 15:48 in 09/11/06 17:14 out  
TRN 56402  
Daily Rate \$ 4.50  
Total Fee \$ 4.50  
Cash Paid \$ 4.50  
Cash Tender \$ 5.00  
Change Due \$ 0.50

Vancouver BC Oct 18, 22/06  
 APPLICANT COPY



**Travel & Employee Expense Claim Form**  
 (In Canadian Dollars) s.17(1), 17(4)(g)(i)

Name: Glenda Coleman-Miller	Employee Number:	Union Name:
Position: Senior Operating Officer - Patient Care	Department: RAH - Executive	
Business Phone: 735-5271	Period From: October 18 to October 22, 2006 - HALIFAX 6 Conference	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0002	71110101001	62414000			\$1,008.30	<input checked="" type="checkbox"/>
201	0002	71110101001	62414000			46.82	<input checked="" type="checkbox"/>
201	0002	71110101001	62414000			47.80	<input checked="" type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
Total						\$1,102.92	<input type="checkbox"/>

Capital Health  
**RECEIVED**  
 NOV 02 2006  
 ACCOUNTS  
 PAYABLE

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: *Glenda Coleman-Miller* Date: October 30, 2006

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: Joanna Pawlyshyn (Print name)	Title: C.O.C. & V.P.	Phone # 735-4101
(Signature) <i>Joanna Pawlyshyn</i>		Date <i>Oct 30/06</i>
Approved By:	Title:	Phone #
(Signature)		Date

- NOTE:**
- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
  - GST amounts included in the expense claims will be calculated by Accounts Payable.
  - Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
  - For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
  - For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
  - See page 2 of this form for expense claim limits.
  - Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
  - Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

*M*





# APPLICANT COPY



Sheraton Vancouver Wall Centre Hotel  
 1088 Burrard Street  
 Vancouver, British Columbia V6Z 2R9 Canada  
 T 604 331 1000 sheratonvancouver.com

Come back soon

CLIENT

TRAVEL AGENT / CHARGE TO

Glenda Coleman-Miller  
 Buksa Associates  
 SNATI2

Room 1458  
 Rate 215.00  
 No. pers. 1  
 Folio. 244182 EX-A  
 Page 1  
 Arrive 18-OCT-06 20:09  
 Depart 22-OCT-06  
 Payment VI

DATE	REFERENCE	DESCRIPTION	DEBIT CREDIT
18-OCT-06	RT1458	Room Charge	215.00
18-OCT-06	RT1458	Room Tax	21.50
18-OCT-06	RT1458	Room GST	12.90
			<del>58.98</del>
19-OCT-06	RT1458	Room Charge	215.00
19-OCT-06	RT1458	Room Tax	21.50
19-OCT-06	RT1458	Room GST	12.90
19-OCT-06	4641	Bottle Water	4.50
19-OCT-06	1792	0001 19:52 s.17(1), 17(4)(g)(i)	1.70
20-OCT-06	RT1458	Room Charge	215.00
20-OCT-06	RT1458	Room Tax	21.50
20-OCT-06	RT1458	Room GST	12.90
20-OCT-06	1 BTL	Bottle Water	4.50
21-OCT-06	RT1458	Room Charge	215.00
21-OCT-06	RT1458	Room Tax	21.50
21-OCT-06	RT1458	Room GST	12.90
22-OCT-06	VI	Visa	1067.28-
Total Charges			1067.28 - 58.98 = 1008.3
Total Credits			1067.28-
Balance Due			0.00

For your convenience, we have prepared this zero-balance folio indicating a \$0 balance on your account. Please be advised that any charges not reflected on this folio will be charged to the credit card on file with the hotel. While this folio reflects a \$0 balance, your credit card may not be charged until after your departure. You are ultimately responsible for paying all of your folio charges in full.

Thank you for choosing Sheraton Vancouver Wall Centre! We look forward to welcoming you back soon!

\*\* continued on the next page \*\*

I agree to remain personally liable for the payment of this account if the corporation or other third party billed fails to pay part or all of these charges.

Signature \_\_\_\_\_

Glenda Coleman-Miller  
 FOLIO 244182 18-OCT-06

APPLICANT COPY

Sheraton Vancouver Wall Centre Hotel -  
1088 Burrard Street  
Vancouver, British Columbia V6Z 2R9 Canada  
T 604 331 1000 sheratonvancouver.com

Come back soon

GUEST

TRAVEL AGENT / CHARGE TO

Glenda Coleman-Miller	Room	1458	
Buksa Associates	Rate	215.00	
	No. pers.	1	
	Folio	244182	EX-A
	Page	2	
	Arrive	18-OCT-06	20:09
	Depart	22-OCT-06	
SNATI2	Payment	VI	

DATE	REFERENCE	DESCRIPTION	DEBIT CREDIT
------	-----------	-------------	--------------

GST Summary for your stay:

Room Revenue GST	51.60
Food & Beverage GST	<del>2.69</del>
Phone/Fax/Copy Services GST	0.09
Other Revenue GST	0.52
Total GST for your stay:	54.90

Sheraton Vancouver Wall Centre GST Vendor # 105576383 RT0001

I agree to remain personally liable for the payment of this account if the corporation or other third party billed fails to pay part or all of these charges.

As a Starwood Preferred Guest you have earned approx 1477  
Starpoints for this visit s.17(1), 17(4)(g)(i)

Glenda Coleman-Miller  
FOLIO 244182 18-OCT-06

**FAX COVER SHEET**

date: <b>Nov 10/06</b>	Time: <b>11:00</b>	Number of pages including cover: <b>2</b>
To: <b>Teresa Rea</b>	Fax: <b>735-0508</b>	
<input type="checkbox"/> <b>CONFIDENTIAL</b>		

from: **Aileen Savage**  
Executive Assistant  
Patient Care Administration  
Room 1108 - ATC  
Royal Alexandra Hospital  
10240 Kingsway  
Edmonton, AB T5H 3V9

Phone: (780) 735-5272  
Fax: (780) 735-5273  
Email: [asavage@cha.ab.ca](mailto:asavage@cha.ab.ca)

- URGENT       FOR YOUR REVIEW       AS REQUESTED       PLEASE COMMENT

**Message:**

If there are any problems with this transmission, please call Aileen Savage @ 735-5272

The contents of this fax are **CONFIDENTIAL** and intended for use only by the individual(s) identified above. If the reader of this message is not the individual, or the employee or agent responsible for delivering the message to the individual, please be aware that communication, distribution or copying of this document is **STRICTLY PROHIBITED**. If you have received this document in error, please notify me immediately by telephone. **THANK YOU.**

**CASH RECEIPT**

**BONNY'S TAXI LTD.**  
 5525 IMPERIAL ST.  
 BURNABY, B.C. V5J 1E8

Date Oct. 20 2006

\$	15.00
Amount Paid Includes G.S.T.	

From \_\_\_\_\_  
 To \_\_\_\_\_  
 Driver \_\_\_\_\_ Car No. \_\_\_\_\_

Telephone: 604-435-6655  
 Thanks for Calling "Bonny's"

APPLICANT

\*\*\*\*\*  
 CHECK # 8211 DATE 10/22/06  
 TABLE # 31 TIME 9:10

ALL MENU : ANGELA114

SEAT#	ITEMS ORDERED	AMOUNT
2	BENNY: MILESTONE	8.79
	SUBTOTAL	8.79
	GST = 6%	0.53
	TOTAL	9.32

\*\*\*\*\*  
 SUBTOTAL 8.79  
 GST = 6% 0.53  
 TOTAL DUE 9.32

G.S.T #13751 2901 RT003

THANK YOU FOR JOINING US AT MILESTONE'S  
 WE SERVE BREAKFAST TILL 4PM EVERY DAY!

AIRPORT EMPLOYEE  
 COMPANY NAME: \_\_\_\_\_

PLEASE PAY YOUR SERVER <<<<<<

**EDMONTON AIRPORTS**  
 GST# R128599776

Car park 0000001009 Phone. (780)890-8439  
 Fax. (780)890-8329

Receipt no. 0322/0784/00803 22.10.06  
 015100 pay parking ticket 32.80 \$  
 18.10.06 17:31 - 22.10.06 14:43  
 Length of stay: 3 Dy 21 Hr. 12 Min.

total amount 32,80 \$  
 accepted total 32,80 \$  
 G.S.T. 6.00 % 1,86 \$

Thank you for your patronage!  
 Please Come Again!  
 \*\* Open 24 hours \*\*  
 \*\* Thank you \*\*

APPLICANT COPY

# MONK McQUEENS

Fresh Seafood & Oyster Bar

\*\*\*\*\*

CHECK # 106637      DATE 10/20/06

TABLE # 70      TIME 10:13PM

\*\*\*\*\* DUPLICATE CHECK \*\*\*\*\*

--      MONKS : Kali 20      --

	SEAT#	ITEMS ORDERED	AMOUNT
Non-Responsive	1		<del>7.00</del>
		DINNER CHOWDER	6.50
		THAT HNT DOT	29.00
Non-Responsive			<del>0.00</del>
		COFFEE	2.00
Non-Responsive			<del>0.25</del>
		CONCIERGE	-7.00
		SUBTOTAL	55.00
		GST	3.30
		PST	1.75
			<del>60.05</del>
		TOTAL	<del>60.05</del>
			<b>37.50</b>

	TYPE	AMOUNT
PROMOTIONS		
	CONCIERGE	-7.00
		<del>-7.00</del>

TOTAL CHK	62.00
PROMO	-7.00
SUBTOTAL	55.00
GST	3.30
PST	1.75

TOTAL DUE      60.05

# OF GUESTS      6

Monks Dinner & Canuck Packages  
 Now on sale !  
 Only \$125.00 per person!  
 3 Course Dinner & Great Game Seats  
 Ask your server for more details  
 or visit our website



APPLICANT COPY

Travel & Employee Expense Claim Form

(In Canadian Dollars) s.17(1), 17(4)(g)(i)

Name: Glenda Coleman-Miller Employee Number: Union Name: Position: Senior Operating Officer Department: Patient Care Administration Business Phone: 735-5271 Period From: Oct. 31 to November 4, 2006

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Table with 8 columns: Bal Unit e.g. 201, Location e.g. 9000, Functional Centre e.g. 71135050044, Account e.g. 69500001, Non-Canadian Currency, Rate, Canadian \$ (including GST), and check box for GST included. Includes a 'RECEIVED' stamp dated NOV 16 2006 and a 'Total' row showing \$1,013.62.

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: [Signature] Date: Nov. 10/06

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approval section with fields for Approved By (Print name), Title, Phone #, and Date. Includes a signature for Joanna Pawlyshyn.

NOTE:

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
GST amounts included in the expense claims will be calculated by Accounts Payable.
Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
See page 2 of this form for expense claim limits.
Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10th Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

Handwritten notes: (NT) 347.64 (T) 975.98





# Fairmont CHÂTEAU LAURIER

1 RIDEAU STREET  
OTTAWA, ON K1N 8S7  
T 613 241 1414 F 613 562 7030  
G.S.T. Registration #139445290

Room/Chambre : 0284  
Folio # : 123061  
Cashier/Cassier # : 308  
Page # : 1 of 2

Group Name/Groupe 5th Annual Fall Invitational Conferenc

Association of Canadian Academic Healthcare Organ  
Glenda Coleman-Miller  
Room 1108  
10240 Kingsway  
Edmonton, AB T5H 3V9

Arrival/Arrivée : 10-31-06  
Departure/Départ : 11-04-06

Date	Description	Additional Information/Supplémentaire	Charges	Credits
10-31-06	Room Charge		179.00	
10-31-06	Room P.S.T. (5%)		8.95	
10-31-06	Room G.S.T. (6%)		10.74	
10-31-06	Destination Marketing Fee		5.07	
10-31-06	DMF - G.S.T. (6%)		0.30	
11-01-06	Internet	#284 :	14.79	
		Non-Responsive	24.94	
11-01-06	Room Charge		179.00	
11-01-06	Room P.S.T. (5%)		8.95	
11-01-06	Room G.S.T. (6%)		10.74	
11-01-06	Destination Marketing Fee		5.07	
11-01-06	DMF - G.S.T. (6%)		0.30	
		Non-Responsive	10.83	
11-02-06	Room Charge		179.00	
11-02-06	Room P.S.T. (5%)		8.95	
11-02-06	Room G.S.T. (6%)		10.74	
11-02-06	Destination Marketing Fee		5.07	
11-02-06	DMF - G.S.T. (6%)		0.30	
11-03-06	Room Charge		179.00	
11-03-06	Room P.S.T. (5%)		8.95	
11-03-06	Room G.S.T. (6%)		10.74	
11-03-06	Destination Marketing Fee		5.07	
11-03-06	DMF - G.S.T. (6%)		0.30	

Guest signature

Signature du client X \_\_\_\_\_

For information or reservations, visit us at

[www.fairmont.com](http://www.fairmont.com) or call Fairmont Hotels & Resorts from:

United States or Canada 1 800 441 1414

Pour information et réservations visitez notre web au

[www.fairmont.com](http://www.fairmont.com) ou téléphoner aux Hôtels Fairmont de:

États-Unis ou Canada 1 800 441 1414

I agree that my liability for this bill is not waived and I agree to be held personally liable in the event that the indicated person, company or association fails to pay for any part of or the full amount of these charges. Overdue balance subject to a surcharge at the rate of 1.5% per month after one month. (18.00% per annum.) I have accepted delivery of The Globe and Mail. Had I refused, I would have been eligible for a \$.50 (Mon-Fri) and \$1.25 (Sat.) credit to my account. (At participating hotels.)

Je me porte personnellement responsable du règlement total de cette note au cas où la compagnie, l'association ou son représentant désigné en refuserait le paiement. Les comptes en souffrance sont sujets à un intérêt de 1.5% par mois après un mois. (18.00% par année) J'ai accepté la livraison du journal The Globe and Mail. Si j'avais refusé, j'aurais pu obtenir un crédit à mon compte de 0.50\$ par jour (du Lundi au Vendredi) et de 1.25\$ le Samedi. (Dans les hôtels participants.)

Thank you for choosing to stay with Fairmont Hotels & Resorts  
Merci d'avoir choisi les Hôtels Fairmont

APPLICANT COPY

*Fairmont*  
CHÂTEAU LAURIER

1 RIDEAU STREET  
OTTAWA, ON K1N 8S7  
T 613 241 1414 F 613 562 7030  
G.S.T. Registration #139445290

Room/Chambre : 0284  
Folio # : 123061  
Cashier/Cassier # : 308  
Page # : 2 of 2

Group Name/Groupe 5th Annual Fall Invitational Conferenc

Association of Canadian Academic Healthcare Orgar  
Glenda Coleman-Miller  
Room 1108  
10240 Kingsway  
Edmonton, AB T5H 3V9

Arrival/Arrivée : 10-31-06  
Departure/Départ : 11-04-06

Date	Description	Additional Information/Supplémentaire	Charges	Credits
		Non-Responsive	32.03	
11-04-06	Visa	XX/XX		898.83
s.17(1), 17(4)(e.1)				
<b>Total</b>			<b>898.83</b>	<b>898.83</b>
<b>Balance Due/Solde</b>			<b>0.00</b>	

GST Summary / Sommaire

Room/Chambre	44.16
F&B/Restauration	1.86
Other/Autres	0.00
<b>Total</b>	<b>46.02</b>

829.27

Guest signature  
Signature du client X \_\_\_\_\_  
For information or reservations, visit us at  
[www.fairmont.com](http://www.fairmont.com) or call Fairmont Hotels & Resorts from:  
United States or Canada 1 800 441 1414  
Pour information et réservations visitez notre web au  
[www.fairmont.com](http://www.fairmont.com) ou téléphoner au Hôtels Fairmont de:  
États-Unis ou Canada 1 800 441 1414

I agree that my liability for this bill is not waived and I agree to be held personally liable in the event that the indicated person, company or association fails to pay for any part of or the full amount of these charges. Overdue balance subject to a surcharge at the rate of 1.5% per month after one month. (18.00% per annum.)  
I have accepted delivery of The Globe and Mail. Had I refused, I would have been eligible for a \$.50 (Mon-Fri) and \$1.25 (Sat.) credit to my account. (At participating hotels.)

Je me porte personnellement responsable du règlement total de cette note au cas où la compagnie, l'association ou son représentant désigné en refuserait le paiement. Les comptes en souffrance sont sujets à un intérêt de 1.5% par mois après un mois. (18.00% par année)  
J'ai accepté la livraison du journal The Globe and Mail. Si j'avais refusé, j'aurais pu obtenir un crédit à mon compte de 0,50\$ par jour (du Lundi au Vendredi) et de 1,25\$ le Samedi. (Dans les hôtels participants.)

Thank you for choosing to stay with Fairmont Hotels & Resorts  
Merci d'avoir choisi nos Hôtels Fairmont

EDMONTON AIRPORTS

MONTANAS FRONT PORCH

EDMONTON, ALBERTA  
 (780) 890-4463

6954 2 0 27650

Server : ROB  
 Check : 600  
 Table : 6  
 Guests : 1  
 TRANS # : 27050

SIDE TIPS  
 Brown toast 1.49  
 SIDE BAKED 1.49  
 Coffee 1.89

TTL: DINE IN 4.87  
 GST .29  
 Amount Due \$5.16

TIP SERVER \$5.16  
 Change \$1.00

T NUMBER: GST#113751 29011000

Please pay your Server  
 Now Hiring, SEND RE-JOB  
 TO ELIZABETH.ARA@MONTANAS.COM  
 2006-10-31 7:11

RECEIPT / RECÜ

Amount/Montant: \$32.00  
 Date: 11/19/06  
 From/De: Airport  
 To/A: Hotel  
 Driver/Chauffeur: 755  
 Tax #:

*Thank you / Merci*

APPLICANT COPY

RECEIPT FOR CAB FARE

Job #:

Amount: \$35.00  
 Date: Nov 19/06

From: \_\_\_\_\_  
 To: \_\_\_\_\_

Cab No. 55  
 Driver: \_\_\_\_\_

GST included in meter fare

VISA  
 MONTANAS  
 Diners Club

LUXE BISTRO  
47 YORK STREET  
PHONE 613-241-8805

THU NOVEMBER 2, 2006  
CHECK #235191-1  
TABLE #8

Non-Responsive

~~1 Hot Soup~~ \$8.00  
\$8.00  
\$9.00

Non-Responsive

~~1 Hot Soup Plate~~ \$16.00  
\$16.00  
\$21.00

Non-Responsive

~~1 Hot Soup Plate~~ \$8.00  
SUB-TOTAL \$73.00  
FOOD P.S.T. \$3.92  
LIQUOR P.S.T. \$2.40  
G.S.T. \$4.38  
~~TOTAL \$83.70~~

s.17(1), 17(4)(g)(i)

THANK-YOU FOR DINING AT LUXE BISTRO  
VISIT OUR WEBSITE  
www.luxebistro.com  
Time: 20:15 2 CUSTOMERS **32.10**

Please Leave Us Your Business  
Cards For Upcoming Promotions

YOU HAVE BEEN SERVED  
BY : NEIL 4

**METROPOLITAIN  
BRASSERIE**

\*\*\*\*\*

Order 101024

700 sussex drive  
OTTAWA ONTARIO, K1N 1K4  
Tel 613 562-1160

11/01/06 9:49 PM  
Table 610 Cust 2  
Waiter 168 BRETT

\*\*\*\*\*

~~1 COQUILLE~~ \$22.99  
Sub-total: 58.99  
GST: 3.54  
PST: ~~3.00~~  
LIQ PST: 3.00

Total Due: 67.97

**22.99**

To reserve your next group function,  
private dining event, or just a good  
time make sure to call Heather or Brenda  
at.....613 562 1160

.....JOIN US FOR HILL HOUR EVERY  
MONDAY-FRIDAY  
4PM-7PM.....



APPLICANT COPY

Travel & Employee Expense Claim Form

(In Canadian Dollars) 17(1), 17(4)(g)(i)

Name: Glenda Coleman-Miller Employee Number: Union Name: Position: Senior Operating Officer Department: RAH - Executive Business Phone: 735-5271 Period From: Oct. 31 to November 4, 2006

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Table with 8 columns: Bal Unit, Location, Functional Centre, Account, Non-Canadian Currency, Rate, Canadian \$ (including GST), and check if GST included. Includes a 'ROUTING & REQUEST' stamp and handwritten notes.

The information on this form will be used to process your

- Please... Read Handle Approve And... Forward Return Keep or Toss Review with Me

To: A/P There was a delay in receiving a receipt. From: Aileen 5-5272 Date: 11/21/06

Canadian \$ (including GST) \$300.00

I hereby certify that the expense claimed by me or on my behalf...

Post # 7664 ©3M 1995

have not been previously

Employee Signature: [Signature] Date: November 16, 2006

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: Joanna Pawlyshyn Title: C.O.O. & V.P. Phone # 735-4101 Date: 20 NOV 06

- NOTE: Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. GST amounts included in the expense claims will be calculated by Accounts Payable. Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.





**ACEN  
ACDSI**

**RECEIPT**

**Academy of Canadian Executive Nurses**

99 Fifth Ave. Suite 10  
Ottawa ON, K1S 5K4  
Tel: 613 235-3033  
Fax: 613 233-6158  
www.acen.ca

TO **Glenda Coleman-Miller  
Capital Health - Royal Alex Hospital**

QTY	DESCRIPTION	LINE TOTAL
1	ACEN ANNUAL EDUCATION DAY - "NURSING LEADERSHIP"	\$ 300.00
<b>PAID</b>		
<b>TOTAL</b>		<b>\$300.00</b>

**ACEN THANKS YOU FOR YOUR CONTINUED SUPPORT!**

APPLICANT COPY

CLARENDA D COLEMAN-MILLER

s.17(1), 17(4)(g)(i)

<sup>SERVICES</sup>  
VIP

DATE 1 2 0 9 2 0 0 6  
D D M M Y Y Y Y


839

PAY TO THE  
ORDER OF

ACEN

\$ 300.00

Three hundred

00/100 DOLLARS  Security features included. Details on back.



ROYAL BANK OF CANADA  
TERWILLEGAR HEIGHTS BRANCH  
14711 40TH AVENUE, UNIT A 121  
EDMONTON, AB T6R 1N1

*Clarendon Miller*

MEMO

s.17(1), 17(4)(e.1)





APPLICANT COPY

Travel & Employee Expense Claim Form

(In Canadian Dollars)  
s.17(1), 17(4)(g)(i)

Name: Glenda Coleman-Miller	Employee Number:	Union Name:
Position: Senior Operating Officer	Department: RAH - Exec	
Business Phone: 735-5271	Period From: January 2007 to March 2007	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0002	71110101001	62410000			\$67.25	<input checked="" type="checkbox"/>
201	0002	71110101001	62410000			117.82	<input checked="" type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
Total						185.07	<input type="checkbox"/>

Capital Health  
**RECEIVED**  
APR 12 2007  
**ACCOUNTS  
PAYABLE**

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: *bcn* Date: April 9, 2007

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: Joanna Pawlyshyn (Print name)	Title: V.P. & C.O.O.	Phone # 735-4101
(Signature) <i>[Signature]</i>	10 Apr 07	Date
Approved By:	Title:	Phone #
(Signature)		Date

NOTE:

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
- GST amounts included in the expense claims will be calculated by Accounts Payable.
- Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
- For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
- For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
- See page 2 of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP



APPLICANT COPY



MILEAGE AND PARKING CLAIM FORM (WITHIN REGION)

Program <i>EXEC</i>	Employee Name <i>Glenda Coleman - Miller</i>	Location <i>RAH</i>	Payroll #
------------------------	---	------------------------	-----------

NOTE: 1) It is the employee's responsibility to maintain adequate records to substantiate all mileage claims to Revenue Canada, Program Management, or Finance upon request. You must be able to provide documentation which shows the date, destination and km travelled on each of your trips. s.17(1), 17(4)(g)(i)

2) Driving to and from work is not considered business travel and must not be claimed.

Month <i>January</i>	Year <i>2007</i>
-------------------------	---------------------

Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	
<i>11/30/06</i> 1		<i>4.50</i>	9			17	<i>6</i>		25	<i>16</i>	<i>4.50</i>	
2			10	<i>16</i>	<i>4.50</i>	18			26			
3			11	<i>6</i>		19			27			
4			12			20			28			
5			13			21			29	<i>16</i>	<i>3.00</i>	
6			14			22			30	<i>16</i>	<i>10.00</i>	
7			15			23	<i>16</i>		31			
8			16	<i>10</i>		24	<i>16</i>	<i>15.00</i>				
										Total	<i>118</i>	<i>41.50</i>

Declaration: I hereby certify that the mileage and parking charges listed above were incurred on Capital Health business and that the amount has not been previously claimed by me or on my behalf.

DISPLAY THIS SIDE UP ON DASHBOARD

DETACH RECEIPT FROM TICKET

EXPIRATION DATE EXPIRATION TIME

DATE ISSUED TIME ISSUED AMOUNT PAID

25/01 07:15 AM

24/07 08:00 AM \$ 15.00

AMOUNT PAID \$ 15.00 15210000 08:00 AM

CREDIT CARD NUMBER s.17(1), 17(4)(e.1)



UNIVERSITY OF ALBERTA

NON TRANSFERABLE



UNIVERSITY OF ALBERTA

RECEIPT

GST # R108102831

UNIVERSITY OF ALBERTA  
HOSPITAL, 114 ST.  
THANK YOU FOR PARKING

REP# 68834  
11/20/06 17:39 LM 1 AM 3 TMD197101  
11/20/06 16:26 IM 11/20/06 17:39 OUT  
TR# 615342  
DAILY RATE \$ 4.50  
TOTAL FEE \$ 4.50  
CASH PAID \$ 4.50  
CASH TENDER \$ 4.50  
CHANGED DND \$ 0.00

REP# 68834  
01/25/07 09:13 LM 1 AM 2 TMD27720  
01/25/07 07:51 IM 01/25/07 09:13 OUT  
TR# 68829  
DAILY RATE \$ 4.50  
TOTAL FEE \$ 4.50  
CASH PAID \$ 4.50  
CASH TENDER \$ 70.00  
CHANGED DND \$ 15.50

Best Copy Possible

UNIVERSITY OF ALBERTA  
HOSPITAL, 114 ST.  
THANK YOU FOR PARKING

UNIVERSITY OF ALBERTA  
HOSPITAL, 114 ST.  
THANK YOU FOR PARKING

APPLICANT COPY

UNIVERSITY OF ALBERTA  
HOSPITAL 114 ST.  
EDMONTON, ALBERTA T6C 2G4

Best Copy Possible

01/29/07 17:34 LN 1 AM 3 TMMW0331  
01/29/07 16:50 IN 01/29/07 17:24 DAF  
TRF# 664103  
DAILY RATE \$ 3.00  
TOTAL FEE \$ 3.00  
CASH PAID \$ 3.00-  
CASH TENDER \$ 3.00  
CHANGE DUE \$ 0.00

UNIVERSITY OF ALBERTA  
HOSPITAL 114 ST.  
EDMONTON, ALBERTA T6C 2G4

Best Copy Possible

REPORT 02563  
01/29/07 17:34 LN 1 AM 3 TMMW0331  
01/29/07 16:50 IN 01/29/07 17:24 DAF  
TRF# 664103  
DAILY RATE \$ 3.00  
TOTAL FEE \$ 3.00  
CASH PAID \$ 3.00-  
CASH TENDER \$ 3.00  
CHANGE DUE \$ 0.00

APPLICANT COPY



MILEAGE AND PARKING CLAIM FORM (WITHIN REGION)

Program <i>EXEC</i>	Employee Name <i>Glenda Coleman-Miller</i>	Location <i>RPH</i>	Payroll #
------------------------	---	------------------------	-----------

NOTE: 1) It is the employee's responsibility to maintain adequate records to substantiate all mileage claims to Revenue Canada, Program Management, or Finance upon request. You must be able to provide documentation which shows the date, destination and km travelled on each of your trips. s.17(1), 17(4)(g)(i)

2) Driving to and from work is not considered business travel and must not be claimed.

Month <i>February</i>	Year <i>2007</i>
--------------------------	---------------------

Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	Date	KM	Parking
1	<i>16</i>		9			17			25		
2	<i>6</i>	<i>4.00</i>	10			18			26		
3			11			19			27		
4			12			20	<i>22</i>	<i>6.00</i>	28	<i>10</i>	
5			13	<i>16</i>	<i>4.50</i>	21			29		
6			14			22			30		
7			15	<i>6</i>		23			31		
8			16			24					
									Total	<i>76</i>	<i>14.50</i>

Declaration: I hereby certify that the mileage and parking charges listed above were incurred on Capital Health business and that the amount has not been previously claimed by me or on my behalf.

APPLICANT COPY

*Kevin Green  
Integrated Willows*

TICKET VOID IF RE-SOLD

DATE: 02/13/07  
 TIME: 5:02PM  
 TICKET NO: 235124  
 EXPIRES: FEB 20 07

5:02PM TUE  
 FEB 20 07

RE-SOLD

INSTRUCTIONS ON BACK  
 PLEASE DO NOT REUSE THIS TICKET

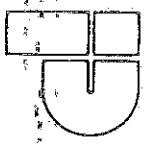
PLACE THIS SIDE UP ON DASH

PLACE THIS SIDE UP ON DASH

s.17(1), 17(4)(e.1)

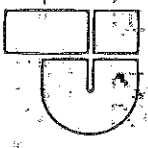
TICKET VOID IF RE-SOLD

imipark



PLACE THIS SIDE UP ON DASH

TICKET VOID IF RE-SOLD



PLACE THIS SIDE UP ON DASH

PROPERTY OF ALBERTA  
 DEPT. 114 OF  
 TRANSPORTATION  
 THANK YOU FOR PARKING  
**Best Copy Possible**

02/13/07 17:02  
 02/13/07 18:00 IN 02/13/07 17:02  
 TOTAL FEE \$ 4.50  
 DASH FEE \$ 4.50  
 DASH TOTAL \$ 9.00

APPLICANT COPY



MILEAGE AND PARKING CLAIM FORM (WITHIN REGION)

Program <i>EXEC</i>	Employee Name <i>Glenda Coleman-Miller</i>	Location <i>RAT</i>	Payroll #
------------------------	---	------------------------	-----------

s.17(1), 17(4)(g)(i)

NOTE: 1) It is the employee's responsibility to maintain adequate records to substantiate all mileage claims to Revenue Canada, Program Management, or Finance upon request. You must be able to provide documentation which shows the date, destination and km travelled on each of your trips.  
2) Driving to and from work is not considered business travel and must not be claimed.

Month <i>March</i>	Year <i>2007</i>
-----------------------	---------------------

Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	Date	KM	Parking
1			9			17			25		
2			10			18			26		
3			11			19			27		
4			12			20	<i>16</i>		28		
5			13			21	<i>32</i>	<i>6.75</i>	29		
6			14	<i>16</i>	<i>4.50</i>	22			30		
7			15			23			31		
8	<i>16</i>		16			24					

Total	<i>80</i>	<i>11.25</i>
-------	-----------	--------------

Declaration: I hereby certify that the mileage and parking charges listed above were incurred on Capital Health business and that the amount has not been previously claimed by me or on my behalf.







# APPLICANT COPY

## Travel & Employee Expense Claim Form

(in Canadian Dollars)  
s.17(1), 17(4)(g)(i)

<b>Name:</b> Glenda Coleman-Miller	<b>Employee Number:</b>	<b>Union Name:</b>
<b>Position:</b> Senior Operating Officer		<b>Department:</b> Exec
<b>Business Phone:</b> 735-5271.	<b>Period From:</b> May 15 to May 15, 2007	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0002	71110101001	61030000			\$20.00	<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
<b>Less Cash Advance</b>							<input type="checkbox"/>
<b>Total</b>						\$20.00	<input type="checkbox"/>

Capital Health  
**RECEIVED**  
JUN 04 2007  
ACCOUNTS  
PAYABLE

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

**Employee Signature:** *Glenda Coleman-Miller* **Date:** May 30, 2007

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

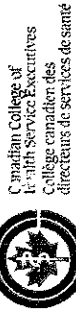
<b>Approved By:</b> Joanna Pawlyshyn (Print name)	<b>Title:</b> V.P. & C.O.O.	<b>Phone #</b> 735-4101
(Signature) <i>[Signature]</i>	<i>[Initials]</i>	<b>Date</b>
<b>Approved By:</b> (Print name)	<b>Title:</b>	<b>Phone #</b>
(Signature)		<b>Date</b>

**NOTE:**

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
- GST amounts included in the expense claims will be calculated by Accounts Payable.
- Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
- For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
- For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
- See page 2 of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP



**RECEIPT**



Canadian College of Health Service Executives  
 Collège canadien des directeurs de services de santé

**Northern Alberta Chapter Power Breakfast Program**

**Date:** May 15, 2007      May 2007 Breakfast

**Received From:** Glenda Coleman-Miller  
 Member  Non Member  Student

Session	Session	Session	Session	Session	Session	Session
1	2	3	4	5	6	X

**Total Paid** ---- \$20.00 ----      Pd by cash

Individual Sessions: M=\$20, NM=\$30  
 Students: M=\$10, NM=\$15  
 All 6 Sessions: M=\$85, NM=\$145



APPLICANT COPY

Travel & Employee Expense Claim Form

(In Canadian Dollars) 17(1), 17(4)(g)(i)

Travel approved Calgary

Name: Glenda C... Employee Number: Union Name: Position: Senior Department: Exec Business Phone: Period From: May 23 to May 25, 2007

Expenses Paid (please specify another organization)

Do not include amounts paid by Capital Health or reimbursed / reimbursable by on the other side of the form

Table with columns: Bal Unit, Location, Centre, Account, Non-Canadian Currency, Rate, Canadian \$ (including GST), and check for GST included. Includes a 'RECEIVED' stamp from Capital Health dated JUN 04 2007.

The information on this form will be used to process...

under section 4 of the Regional Health Authorities (Ministerial) Regulation and

I hereby certify that the expenses claimed by me or on my behalf...

above were incurred on Capital Health business and have not been previously claimed by Capital Health or other organization.

Employee Signature: [Signature]

Date: May 30, 2007

I hereby certify that the mileage claimed is for business expenses and rate at which mileage is being claimed.

Approved By: Joan (Print name), (Signature), Approved By: (Print name), (Signature)

Title: V.P. & C.O.O. Phone # 735-4101 Date: 01 JUN 07 Title: Phone # 1080-46 Date: NT 26-55

NOTE:

- Expense claim must be approved by the appropriate manager. The appropriate manager is required to provide written approval. GST amounts in this form will be calculated by Accounts Payable. Fully completed expense claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed. For all employees, expense reimbursements will be deposited to employee bank account. For physicians, expense reimbursements will be mailed through the inter-office mail system. See page 2 of this form for more information. Approved claim forms should be sent to Accounts Payable (Capital Health Centre, North Tower - 10th Fl., 10030 - 107 Street, Edmonton, Alberta T5C 0E8). Out of province claims require a Level 4 Approval Form (CH 198) in advance authorized by a COO or VP.

authorized and must be supported by original receipts or a copy as certified by the individual items that are not supported by original invoices or do not have all the information required to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval. Expense reimbursements will be deposited to employee bank account. For physicians, expense reimbursements will be mailed through the inter-office mail system. See page 2 of this form for more information. Approved claim forms should be sent to Accounts Payable (Capital Health Centre, North Tower - 10th Fl., 10030 - 107 Street, Edmonton, Alberta T5C 0E8). Out of province claims require a Level 4 Approval Form (CH 198) in advance authorized by a COO or VP.

**Recommended Coding**

- Local Travel – Staff – 62410000
- Staff Local Travel – Taxi – 62410001
- Staff Travel – UNA – 62410002
- Staff Provincial Travel – 62412000 (all expenses)
- Staff Out of Province Travel – 62414000 (all expenses)

- Catering – 69600000
- Meals – 62410000
- Mileage – 62410000
- Course Registration & Materials – 61030000

Date	Particulars (Describe Purpose of Trip & Location)	Accommodation	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
May 23 - 25, 2007	Vehicle Travel to/from Calgary for Healthy Mothers/Healthy Babies Conference				\$258.00		600
May 23 - 25, 2007	Healthy Mothers/Healthy Babies Conference - Calgary	723	12.07			113.58	
<b>Total km</b>							
<b>Rate as outlined in Section 2 – Travel below @</b>							
<b>Totals</b>		\$723	\$12.07		\$258.00	113.58	\$1,107.01

**EXPENSE LIMITS**

**1. Meal Allowances**

When traveling on Capital Health business, the employee is reimbursed at the Per Diem meal allowance of:

- Breakfast \$8.50 (if the departure time is before 7:30 a.m.)
- Lunch \$10.75 (if the departure time is before 1:00 p.m.)
- Dinner \$19.20 (if the departure time is before 6:30 p.m.)

For meal expenses that exceed the above amounts, the employee may approve higher amounts, with receipts, provided these are reasonable.

Meal expenses must be supported by restaurant receipts from organizations whose representatives attended the luncheon.

**2. Travel**

- Use of personal automobile – From March 1, 2006, approved travel in a fiscal year (April 1 to March 31 otherwise).
- Business car insurance is reimbursable up to \$260 effective March 1, 2006, out of scope employees requirements on a regular and continuing basis as follows:
  1. Monthly travel in excess of 340 kilometers; or
  2. Monthly expense equivalent to four (4) return car trips; or
  3. Daily requirements to utilize personal vehicle in excess of 100 kilometers.
- If union contract rate differs from \$0.43 then contract rate shall apply.
- Includes all forms of transportation costs, including taxi, bus, train, and airfare.
- Driving to and from work is not considered business travel.

reimbursed at the Per Diem meal allowance of:

- if return time is later than 7:30 a.m.
- if return time is later than 1:00 p.m.
- if return time is later than 6:30 p.m.

may approve higher amounts, with receipts, provided these are reasonable.

Receipts must be supported by a credit card receipt) and information on either the names of the individuals or the organization.

Travel is reimbursed at the general rate of \$0.43 per km for the first 15,000 kilometers of travel for each kilometer there after (except where collective agreement specifies otherwise).

Receipts must be supported by receipts in accordance with Capital Health Policy.

Travel is reimbursed at the general rate of \$0.43 per km for the first 15,000 kilometers of travel for each kilometer there after (except where collective agreement specifies otherwise).

Travel is reimbursed at the general rate of \$0.43 per km for the first 15,000 kilometers of travel for each kilometer there after (except where collective agreement specifies otherwise).

Travel is reimbursed at the general rate of \$0.43 per km for the first 15,000 kilometers of travel for each kilometer there after (except where collective agreement specifies otherwise).



APPLICANT COPY

Sheraton Suites Calgary EAU CLAIRE

255 BARCLAY PARADE SW CALGARY, ALBERTA T2P 5C2 PHONE (403) 266-7200 FAX (403) 266-1300

817 ROOM 219.00 RATE 1 NO. PERS. 601789 A FOLIO 1 PAGE 22-MAY-07 20:05 ARRIVE 25-MAY-07 DEPART MC 11:34 PAYMENT TRAVEL CHARGE

MRS Glenda Coleman-miller Royal Alexander Hospital 10240 Kingsway Edmonton, AB T5H 3B9 0522AP

Table with columns: DATE, REFERENCE, DESCRIPTION, CHARGES • CREDITS. Includes entries for Room Charge, DMF, Alberta Tourism Levy, GST, Valet Pkg, In-room Internet, and Master Card. Total-Due 0.00. Includes handwritten '849.01' and 'Non-Responsive' annotations.

I agree to remain personally liable for the payment of this account if the corporation or other third party billed fails to pay part or all of these charges.

SIGNATURE

For Reservations Call 1-888-784-8370

MRS Glenda Coleman-miller ROOM 817 DEPART 25-MAY-07 AGENT CA FOLIO 601789 22-MAY-07

The Sheraton Suites Calgary Eau Claire is OWNED AND OPERATED BY EAU CLAIRE HOTEL OPERATING TRUST



APPLICANT COPY

**Sheraton  
Suites Calgary**  
EAU CLAIRE

255 BARCLAY PARADE SW  
CALGARY, ALBERTA T2P 5C2  
PHONE (403) 266-7200  
FAX (403) 266-1300

<b>G</b> MRS Glenda Coleman-miller <b>U</b> <b>E</b> Royal Alexander Hospital <b>S</b> 10240 Kingsway <b>T</b> Edmonton, AB T5H 3B9 0522AP	ROOM	817					
	RATE	219.00					
	NO. PERS.	1					
	FOLIO	601789	A				
	PAGE	2					
	ARRIVE	22-MAY-07		20:05			
	DEPART	25-MAY-07					
	PAYMENT	MC		11:34			

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E

DATE REFERENCE DESCRIPTION CHARGES • CREDITS

EXPENSE REPORT SUMMARY

Date	Room & Tax	Food & Bev	Telephone	Other	Total	Payment
22-MAY-07	241.12	0.00	0.00	32.93	274.05	0.00
23-MAY-07	241.12	0.00	0.00	72.40	313.52	0.00
24-MAY-07	241.12	112.85	0.00	32.93	386.90	0.00
25-MAY-07	0.00	0.00	0.00	0.00	0.00	974.47
<b>Total</b>	<b>723.36</b>	<b>112.85</b>	<b>0.00</b>	<b>138.26</b>	<b>974.47</b>	<del>974.47</del> <b>849.01</b>

We would certainly appreciate any feedback that you may have. Please send to Ross Meredith at rmeredith@sheratonsuites.com.

GST Summary

GST Room Revenue	39.81
GST Food and Beverage	7.00
GST Telephone	0.00
GST Other Revenue	6.06
<b>Total GST</b>	<b>52.87</b>

139445290 RT0021

I agree to remain personally liable for the payment of this account if the corporation or other third party billed fails to pay part or all of these charges.

SIGNATURE

As a Starwood Preferred Guest you have earned at least 2 Starpoints for each \$1 US Dollar spent.

For Reservations  
Call 1-888-784-8370

MRS Glenda Coleman-miller	ROOM	DEPART	AGENT
FOLIO 601789 22-MAY-07	817	25-MAY-07	CA

The Sheraton Suites Calgary Eau Claire is  
OWNED AND OPERATED BY EAU CLAIRE HOTEL OPERATING TRUST





APPLICANT COPY *Reimburse 18 May 07*  
**Travel & Employee Expense Claim Form**

*(In Canadian Dollars)*  
 s.17(1), 17(4)(g)(i)

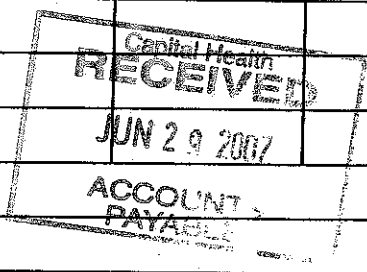
*Meals*

Name: Glenda Coleman-Miller	Employee Number:	Union Name:
Position: Senior Operating Officer	Department: Exec	
Business Phone: 735-5271	Period From: June 25 to June 25, 2007	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included	
201	0002	71110101001	62410000			\$213.98	<input checked="" type="checkbox"/>	
			698				<input type="checkbox"/>	
							<input type="checkbox"/>	
							<input type="checkbox"/>	
							<input type="checkbox"/>	
							<input type="checkbox"/>	
							<input type="checkbox"/>	
Less Cash Advance							<input type="checkbox"/>	
<b>Total</b>							\$213.98	<input checked="" type="checkbox"/>

201  
 (M)



The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: *Glenda Coleman-Miller* Date: June 27, 2007

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: Joanna Pawlyshyn <i>(Signature)</i>	Title: V.P. & C.O.O.	Phone # 735-4101
<i>(Signature)</i>	<i>27 JUN 07</i>	Date
Approved By:	Title:	Phone #
<i>(Signature)</i>		Date

**NOTE:**

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
- GST amounts included in the expense claims will be calculated by Accounts Payable.
- Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
- For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
- For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
- See page 2 of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

**EXPENSE ACCOUNT DETAILS**

**Recommended Coding**

- Local Travel – Staff - 62410000
- Staff Local Travel – Taxi – 62410001
- Staff Travel – UNA – 62410002
- Staff Provincial Travel – 62412000 (all expenses)
- Staff Out of Province Travel – 62414000 (all expenses)
- Catering – 69600000
- Meals - 62410000
- Mileage – 62410000
- Course Registration & Materials – 61030000

Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
May 18, 07	Recruitment Dinner, G. Coleman-Miler, G. Burnett, K. Lee s.17(1), 17(4)(g)(i)		\$213.98				
<b>Total km</b>							
<b>Rate as outlined in Section 2 – Travel below @</b>							
<b>Totals</b>			\$213.98				

**EXPENSE LIMITS**

**1. Meal Allowances**

When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:

- Breakfast \$8.50 (if the departure time is earlier or the return time is later than 7:30 a.m.)
- Lunch \$10.75 (if the departure time is earlier or the return time is later than 1:00 p.m.)
- Dinner \$19.20 (if the departure time is earlier or the return time is later than 6:30 p.m.)

For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.

Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.

**2. Travel**

- Use of personal automobile – From March 1, 2006, reimbursement at the general rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
- Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
- Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
  1. Monthly travel in excess of 340 kilometers; or
  2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
  3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
- If union contract rate differs from \$0.43 then contract rate must be used.
- Includes all forms of transportation costs, including taxis and buses for local travel.
- Driving to and from work is not considered business travel and cannot be claimed.

**3. Advance**

Travel advance may be requested provided travel expenses are likely to exceed \$500.

*Reimbursement*

RIC'S GRILL - DOWNTOWN  
Seafood, Steak and Chophouse  
10190 104 Street  
Edmonton, AB  
(780) 429-4333  
G.S.T. #R887052702

s.17(1), 17(4)(g)(i)

Date: May/18/07 09:26PM  
Card Type: VISA

s.17(1), 17(4)(e.1)

Acct #: \_\_\_\_\_  
Exp Date: \_\_\_\_\_  
Auth Code: 044851  
Check: 4795  
Table: 33/1  
Server: 140 Steve R

Subtotal: 193.98

TIP: 20.00

TOTAL: 213.98

SIGNATURE \_\_\_\_\_

I AGREE TO PAY THE ABOVE AMOUNT  
AS PER THE CARDHOLDER AGREEMENT

RIC'S GRILL - DOWNTOWN  
Seafood, Steak and Chophouse  
10190 104 Street  
Edmonton, AB  
(780) 429-4333  
G.S.T. #R887052702  
140 Steve R  
**Best Copy Possible**

Qty	Description	Rate	Amount
3	SOFT DRINK	0.00	0.00
1	COMP SERVICE	0.00	0.00
1	4oz DRINK	33.00	33.00
1	Sautéed Mushroom	4.00	4.00
1	SOY STEAK	25.00	25.00
1	CRISPY ONIONS	3.00	3.00
1	400 KING SALAD	18.00	18.00
1	POZ FILET MIGNON	29.00	29.00
1	CHESTER DRAPE	31.00	31.00
1	RY 555 SHRIMP	40.00	40.00

Subtotal 193.00  
GST 10.98  
Amount Due 193.98

PLEASE PAY YOUR SERVER  
\*\*\*\*\*



**Travel & Employee Expense Claim Form**

(In Canadian Dollars)  
s.17(1), 17(4)(g)(i)

*R. Dimer*

Name: Glenda Coleman-Miller	Employee Number:	Union Name:
Position: Senior Operating Officer	Department: Exec	
Business Phone: 735-5271	Period From: June 25 to June 25, 2007	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0002	71110101001	62410000			\$1,585.66	<input checked="" type="checkbox"/>
			<i>6960000</i>				<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
<b>Total</b>						\$1,585.66	<input checked="" type="checkbox"/>

Capital Health  
**RECEIVED**  
 JUN 29 2007  
 ACCOUNTS  
 PAYABLE

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: <i>Glenda Coleman-Miller</i>	Date: June 27, 2007
--	---------------------

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: Joanna Pawlyshyn (Print name)	Title: V.P. & C.O.O.	Phone # 735-4101
(Signature) <i>[Signature]</i>	<i>27 JUN 07</i>	Date
Approved By:	Title:	Phone #
(Signature)		Date

**NOTE:**

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
- GST amounts included in the expense claims will be calculated by Accounts Payable.
- Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
- For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
- For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
- See page 2 of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

*u*

**Recommended Coding**

- Local Travel – Staff - 62410000
- Staff Local Travel – Taxi – 62410001
- Staff Travel – UNA – 62410002
- Staff Provincial Travel – 62412000 (all expenses)
- Staff Out of Province Travel – 62414000 (all expenses)
- Catering – 69600000
- Meals - 62410000
- Mileage – 62410000
- Course Registration & Materials – 61030000

Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
June 25/07	Retirement Dinner for Maria Devlin		\$1,585.66				
	Joanna Pawlyshyn, Glenda Coleman-Miller, Lois Stefaniuk, Dr. Gramlich, Dr. Bailey, W. Morgan-Eckley, V. Glassman, S. Rees, K. Lee, G. Aguilon, M. Armstrong, R. bremer, S. Young, G. Burnett, C. Toner, W. Westwood; R. Darda						
<b>Total km</b>							
<b>Rate as outlined in Section 2 – Travel below @</b>							
<b>Totals</b>			\$1,585.66				

**EXPENSE LIMITS**

1. **Meal Allowances**  
 When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:
  - Breakfast \$8.50 (if the departure time is earlier or the return time is later than 7:30 a.m.)
  - Lunch \$10.75 (if the departure time is earlier or the return time is later than 1:00 p.m.)
  - Dinner \$19.20 (if the departure time is earlier or the return time is later than 6:30 p.m.)
 For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.  
 Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.
  
2. **Travel**
  - Use of personal automobile – From March 1, 2006, reimbursement at the general rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
  - Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
  - Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
    1. Monthly travel in excess of 340 kilometers; or





# APPLICANT COPY

## Travel & Employee Expense Claim Form

(In Canadian Dollars) (g)(i)

Name: Glenda Coleman-Miller	Employee Number:	Union Name:
Position: Senior Operating Officer	Department: Exec	
Business Phone: 735-5271	Period From: June 28/07 to June 28/07	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0002	71110101001	61030000			\$2,862.00	<input checked="" type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
<b>Total</b>						\$2,862.00	<input checked="" type="checkbox"/>

RECEIVED  
JUL 20 2007  
ACCOUNTS  
PAYABLE

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: *Glenda Coleman-Miller* Date: *July 6/07*

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: Joanna Pawlyshyn <i>(Signature)</i>	Title: V.P. & C.O.O.	Phone # 735-4101
<i>(Signature)</i>	<i>17 JULY 07</i>	Date
Approved By:	Title:	Phone #
<i>(Signature)</i>	<i>LB</i>	Date

**NOTE:**

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
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- Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP





APPLICANT COPY

Laraque (Savage), Aileen

From: Tara West [halifax@BUKSA.com]  
 Sent: Tuesday, July 03, 2007 3:09 PM  
 To: Laraque (Savage), Aileen  
 Subject: Halifax 7 Symposium - Confirmation and Receipt  
 Follow Up Flag: Follow up  
 Flag Status: Blue  
 Attachments: ATT3034783.txt



**Confirmation and Receipt  
 re Safety Symposium  
 003 RT 0001**

7/18/07

*Accounts Payable*

*Please note - Travel*

*Approval forms not completed as participants are not yet confirmed.*

*We were required to provide payment on credit card with 4 names.*

*Payment for all 4 were paid by Glenda Ledeman-Miller.*

*Actual participants will be decided at a later date.*

*Travel approval forms will*

thcare Safety Symposium at the Westin Ottawa (11

mposium

	Fee	Owing
	\$ 715.50	\$ 0.00
	\$ 715.50	\$ 0.00

9983 Edm."

not have been available.

## APPLICANT COPY

Room Type	Check In	Check Out
Deluxe - 1 Guest	10/10/2007	10/14/2007
Rate per night	\$255.00	
Number of Beds/Special Requirements	1 bed	
Confirmation Number	230291	

This room rate is not included in your registration fees. Your room has been guaranteed using the credit card information provided on the online registration form. The hotel will finalize your bill when you check out. If you need to make any changes to this information please email [halifax@buksa.com](mailto:halifax@buksa.com).

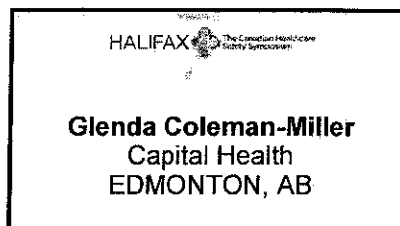
**"Swiss Cheese" Lecture**

Yes, I will attend the lecture

For details including session descriptions and start times, please refer to [www.buksa.com/halifax](http://www.buksa.com/halifax).

Your nametag will appear as shown here including First Name, Last Name, Organization, City and Province:

If you require changes to this information please notify us by email at [halifax@buksa.com](mailto:halifax@buksa.com). Please mention "Halifax 7" in the subject of your email.



We look forward to seeing you in Ottawa!

Yours Sincerely,  
Sean Jones

Halifax 7: The Canadian Healthcare Safety Symposium  
 BUKSA Conference Management and Program Development  
 Suite 307, 10328 - 81 Avenue NW, EDMONTON, AB T6E 1X2  
 Phone: (780) 436-0983 x229 Fax: (780) 437-5984 Email: [halifax@buksa.com](mailto:halifax@buksa.com)  
[www.buksa.com/halifax](http://www.buksa.com/halifax)

## APPLICANT COPY

**Laraque (Savage), Aileen**

**From:** Tara West [halifax@BUKSA.com]  
**Sent:** Thursday, June 28, 2007 5:19 PM  
**To:** Laraque (Savage), Aileen  
**Subject:** Halifax 7 Symposium - Confirmation and Receipt  
**Follow Up Flag:** Follow up  
**Flag Status:** Blue  
**Attachments:** ATT2766362.txt



**Confirmation and Receipt**  
**The Canadian Healthcare Safety Symposium**  
**GST # 86867 4003 RT 0001**

Ms. Wendy Morgan-Eckley  
 Director, Royal Alexandra Hospital </P>  
 Capital Health  
 Room 5227-2, ATC  
 Royal Alexandra Hospital  
 EDMONTON AB T5H 3V9

Dear Ms. Morgan-Eckley,

Thank you for registering for Halifax 7: The Canadian Healthcare Safety Symposium at the Westin Ottawa (11 Colonel By Drive). Below is your registration information:

**Halifax 7: The Canadian Healthcare Safety Symposium**

Details	Status	Fee	Owing
Early Bird Registration	Paid	\$ 715.50	\$ 0.00

<b>TOTAL</b>		<b>\$ 715.50</b>	<b>\$ 0.00</b>
--------------	--	------------------	----------------

**Payment and Receipt Details**

<b>Cheque No.</b>	
<b>Name on Card</b>	Glenda Coleman-Miller
<b>Card Number</b>	s.17(1), 17(4)(e.1)
<b>Expiry Date</b>	
<b>Receipt No.</b>	253.00
<b>Receipt Date</b>	6/28/2007
<b>Receipt Total</b>	\$ 715.50

If you paid by credit card your statement will read "BUKSA Assoc. (780) 436-0983 Edm."

**The Westin Ottawa - Accommodation Booking**

Please read carefully as your room preferences may not have been available.

Room Type	Check In	Check Out
Deluxe - 1 Guest	10/10/2007	10/14/2007

## APPLICANT COPY

Rate per night	\$255.00
Number of Beds/Special Requirements	1 bed
Confirmation Number	230294

This room rate is not included in your registration fees. Your room has been guaranteed using the credit card information provided on the online registration form. The hotel will finalize your bill when you check out. If you need to make any changes to this information please email [halifax@buksa.com](mailto:halifax@buksa.com).

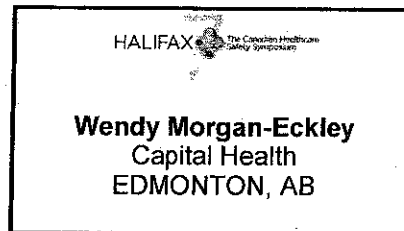
**"Swiss Cheese" Lecture**

Yes, I will attend the lecture

For details including session descriptions and start times, please refer to [www.buksa.com/halifax](http://www.buksa.com/halifax).

Your nametag will appear as shown here including First Name, Last Name, Organization, City and Province:

If you require changes to this information please notify us by email at [halifax@buksa.com](mailto:halifax@buksa.com). Please mention "Halifax 7" in the subject of your email.



We look forward to seeing you in Ottawa!

Yours Sincerely,  
Sean Jones

**Halifax 7: The Canadian Healthcare Safety Symposium**  
 BUKSA Conference Management and Program Development  
 Suite 307, 10328 - 81 Avenue NW, EDMONTON, AB T6E 1X2  
 Phone: (780) 436-0983 x229 Fax: (780) 437-5984 Email: [halifax@buksa.com](mailto:halifax@buksa.com)  
[www.buksa.com/halifax](http://www.buksa.com/halifax)

## APPLICANT COPY

**Laraque (Savage), Aileen**

**From:** Tara West [halifax@BUKSA.com]  
**Sent:** Tuesday, July 03, 2007 3:09 PM  
**To:** Laraque (Savage), Aileen  
**Subject:** Halifax 7 Symposium - Confirmation and Receipt  
**Follow Up Flag:** Follow up  
**Flag Status:** Blue  
**Attachments:** ATT3034795.txt

**HALIFAX**The Canadian Healthcare  
Safety Symposium

**Confirmation and Receipt**  
**The Canadian Healthcare Safety Symposium**  
**GST # 86867 4003 RT 0001**

Ms. Carmel Toner  
 Acting Director, Royal Alexandra Hospital </P>  
 Capital Health  
 Room 2427, ATC  
 Royal Alexandra Hospital  
 EDMONTON AB T5H 3V9

Dear Ms. Toner,

Thank you for registering for Halifax 7: The Canadian Healthcare Safety Symposium at the Westin Ottawa (11 Colonel By Drive). Below is your registration information:

**Halifax 7: The Canadian Healthcare Safety Symposium**

Details	Status	Fee	Owing
Early Bird Registration	Paid	\$ 715.50	\$ 0.00

<b>TOTAL</b>		<b>\$ 715.50</b>	<b>\$ 0.00</b>
--------------	--	------------------	----------------

**Payment and Receipt Details**

<b>Cheque No.</b>	
<b>Name on Card</b>	Glenda Coleman-Miller
<b>Card Number</b>	s.17(1), 17(4)(e.1)
<b>Expiry Date</b>	
<b>Receipt No.</b>	258.00
<b>Receipt Date</b>	6/29/2007
<b>Receipt Total</b>	\$ 715.50

If you paid by credit card your statement will read "BUKSA Assoc. (780) 436-0983 Edm."

**The Westin Ottawa - Accommodation Booking**

Please read carefully as your room preferences may not have been available.

&lt;/TR&gt;

Room Type	Check In	Check Out

## APPLICANT COPY

<b>Deluxe - 1 Guest</b>	10/10/2007	10/14/2007
Rate per night	\$255.00	
Number of Beds/Special Requirements	1 bed	
<b>Confirmation Number</b>	<b>230292</b>	

This room rate is not included in your registration fees. Your room has been guaranteed using the credit card information provided on the online registration form. The hotel will finalize your bill when you check out. If you need to make any changes to this information please email [halifax@buksa.com](mailto:halifax@buksa.com).

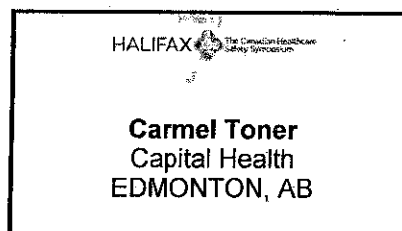
**"Swiss Cheese" Lecture**

Yes, I will attend the lecture

For details including session descriptions and start times, please refer to [www.buksa.com/halifax](http://www.buksa.com/halifax).

Your nametag will appear as shown here including First Name, Last Name, Organization, City and Province:

If you require changes to this information please notify us by email at [halifax@buksa.com](mailto:halifax@buksa.com). Please mention "Halifax 7" in the subject of your email.



We look forward to seeing you in Ottawa!

Yours Sincerely,  
Sean Jones

Halifax 7: The Canadian Healthcare Safety Symposium  
 BUKSA Conference Management and Program Development  
 Suite 307, 10328 - 81 Avenue NW, EDMONTON, AB T6E 1X2  
 Phone: (780) 436-0983 x229 Fax: (780) 437-5984 Email: [halifax@buksa.com](mailto:halifax@buksa.com)  
[www.buksa.com/halifax](http://www.buksa.com/halifax)

## APPLICANT COPY

**Laraque (Savage), Aileen**

**From:** Tara West [halifax@BUKSA.com]  
**Sent:** Tuesday, July 03, 2007 3:09 PM  
**To:** Laraque (Savage), Aileen  
**Subject:** Halifax 7 Symposium - Confirmation and Receipt  
**Follow Up Flag:** Follow up  
**Flag Status:** Blue  
**Attachments:** ATT3034776.txt

**HALIFAX**  The Canadian Healthcare  
Safety Symposium

**Confirmation and Receipt  
The Canadian Healthcare Safety Symposium  
GST # 86867 4003 RT 0001**

Ms. Valerie Glassman  
Program Manager, Royal Alexandra Hospital  
Capital Health  
Room 4228-1, ATC  
Royal Alexandra Hospital  
EDMONTON AB T5H 3V9

Dear Ms. Glassman,

Thank you for registering for Halifax 7: The Canadian Healthcare Safety Symposium at the Westin Ottawa (11 Colonel By Drive). Below is your registration information:

**Halifax 7: The Canadian Healthcare Safety Symposium**

Details	Status	Fee	Owing
Early Bird Registration	Paid	\$ 715.50	\$ 0.00

<b>TOTAL</b>		\$ 715.50	\$ 0.00
--------------	--	-----------	---------

**Payment and Receipt Details**

<b>Cheque No.</b>	
<b>Name on Card</b>	Glenda Coleman-Miller
<b>Card Number</b>	s.17(1), 17(4)(e.1)
<b>Expiry Date</b>	
<b>Receipt No.</b>	257.00
<b>Receipt Date</b>	6/29/2007
<b>Receipt Total</b>	\$ 715.50

If you paid by credit card your statement will read "BUKSA Assoc. (780) 436-0983 Edm."

**The Westin Ottawa - Accommodation Booking**

Please read carefully as your room preferences may not have been available.

Room Type	Check In	Check Out < /P>
<b>Deluxe - 1 Guest</b>	10/10/2007	10/14/2007
<b>Rate per night</b>	\$255.00	

## APPLICANT COPY

Number of Beds/Special Requirements	1 bed
Confirmation Number	230293

This room rate is not included in your registration fees. Your room has been guaranteed using the credit card information provided on the online registration form. The hotel will finalize your bill when you check out. If you need to make any changes to this information please email [halifax@buksa.com](mailto:halifax@buksa.com).

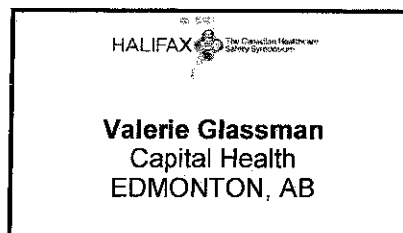
**"Swiss Cheese" Lecture**

Yes, I will attend the lecture

For details including session descriptions and start times, please refer to [www.buksa.com/halifax](http://www.buksa.com/halifax).

Your nametag will appear as shown here including First Name, Last Name, Organization, City and Province:

If you require changes to this information please notify us by email at [halifax@buksa.com](mailto:halifax@buksa.com). Please mention "Halifax 7" in the subject of your email.



We look forward to seeing you in Ottawa!

Yours Sincerely,  
Sean Jones

**Halifax 7: The Canadian Healthcare Safety Symposium**  
 BUKSA Conference Management and Program Development  
 Suite 307, 10328 - 81 Avenue NW, EDMONTON, AB T6E 1X2  
 Phone: (780) 436-0983 x229 Fax: (780) 437-5984 Email: [halifax@buksa.com](mailto:halifax@buksa.com)  
[www.buksa.com/halifax](http://www.buksa.com/halifax)





Capital Health

# APPLICANT COPY

## Travel & Employee Expense Claim Form

(In Canadian Dollars) s.17(1), 17(4)(g)(i)

Name: Glenda Coleman-Miller	Employee Number:	Union Name:
Position: Senior Operating Officer	Department: Executive	
Business Phone: 735-5271	Period From: July 9, 2007 to July 9, 2007	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0002	711101001	62410000			\$88.97	<input checked="" type="checkbox"/>
		71110101001					<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
Total						\$88.97	<input checked="" type="checkbox"/>

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: *Glenda Coleman-Miller* Date: July 9, 2007

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: Joanna Pawlyshyn (Print name)	Title: V.P. & C.O.O.	Phone # 735-4101
(Signature)	17 JULY 07	Date
Approved By:	Title:	Phone #
(Signature)	KB	Date

### NOTE:

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
- GST amounts included in the expense claims will be calculated by Accounts Payable.
- Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
- For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
- For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
- See page 2 of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

## EXPERIMENTAL COPY

Recommended Coding							
<ul style="list-style-type: none"> <li>• Local Travel – Staff - 62410000</li> <li>• Staff Local Travel – Taxi – 62410001</li> <li>• Staff Travel – UNA – 62410002</li> <li>• Staff Provincial Travel – 62412000 (all expenses)</li> <li>• Staff Out of Province Travel – 62414000 (all expenses)</li> </ul>				<ul style="list-style-type: none"> <li>• Catering – 69600000</li> <li>• Meals - 62410000</li> <li>• Mileage – 62410000</li> <li>• Course Registration &amp; Materials – 61030000</li> </ul>			
Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
July 9/07	Farewell Luncheon for Dr. Faught - Lois Stefaniuk, Glenda Coleman-Miller, Dr. Dickout		\$88.97				
Total km							
Rate as outlined in Section 2 – Travel below @							
<b>Totals</b>		\$88.97					

**EXPENSE LIMITS**

**1. Meal Allowances**

When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:

- Breakfast     \$8.50 (if the departure time is earlier or the return time is later than 7:30 a.m.)
- Lunch         \$10.75 (if the departure time is earlier or the return time is later than 1:00 p.m.)
- Dinner        \$19.20 (if the departure time is earlier or the return time is later than 6:30 p.m.)

For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.

Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.

**2. Travel**

- Use of personal automobile – From March 1, 2006, reimbursement at the general rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
- Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
- Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
  1. Monthly travel in excess of 340 kilometers; or
  2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
  3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
- If union contract rate differs from \$0.43 then contract rate must be used.
- Includes all forms of transportation costs, including taxis and buses for local travel.
- Driving to and from work is not considered business travel and cannot be claimed.

APPLICANT COPY

CHARACTERS REST  
10257 - 105 STREET  
EDMONTON, AB.  
T5J 1E3  
780-421-4100  
GST# 89206-4429

CHARACTERS REST  
10257 - 105 Street  
EDMONTON, AB.  
T5J 1E3  
(780) 421-4100  
GST# 89206-4429

Date: Ju109'07 01:14PM  
Card Type: M/C  
Acct #:  
Exp Date:  
Auth Code: 005495  
Check: 1385  
Table: 14/1  
Server: 110 SNOW S  
GLEND A COLEMAN-MILLER

s.17(1), 17(4)(e.1)

Subtotal: 78.97

GRATUITY 10.00

TOTAL 88.97

SIGNATURE *Glendon Miller*  
\*\* Customer Copy \*\*

110 SNOW S

Tbl 14/1 Chk 1385 Gst 4  
Ju109'07 12:10PM

1 CUP OF SOUP	4.00
2 SOUP OF DAY @ 6.00	12.00
1 ROMAINE SALAD	7.00
1 SALAD GREENS	6.00
1 REUBIN SANDWICH	15.00
1 SEARD SALMON	18.00
3 COFFEE @ 2.75	8.25
1 CAPPUCCINO	4.25

Subtotal 74.50  
GST 4.47  
01:06 Amount Du 78.97

WELCOME TO CHARACTERS!  
& HAVE A GREAT DAY!!



# APPLICANT COPY

## Travel & Employee Expense Claim Form

(In Canadian Dollars) s.17(1), 17(4)(g)(i)

Name: Glenda Coleman-Miller	Employee Number:	Union Name:
Position: Senior Operating Officer	Department: RAH - Exec	
Business Phone: 735-5271	Period From: April 2007 to June 2007	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0002	71110101001	62410000			\$120.83	<input checked="" type="checkbox"/>
201	0002	71110101001	62410000			54.95	<input checked="" type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
Total						\$175.78	<input type="checkbox"/>

Capital Health  
**RECEIVED**  
JUL 26 2007  
**ACCOUNTS  
PAYABLE**

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: *[Signature]*

Date: July 19, 2007

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: Joanna Pawlyshyn (Print name)	Title: V.P. & C.O.O.	Phone # 735-4101
(Signature) <i>[Signature]</i>	20 JULY 07	Date
Approved By:	Title:	Phone #
(Signature)		Date

### NOTE:

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
- GST amounts included in the expense claims will be calculated by Accounts Payable.
- Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
- For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
- For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
- See page 2 of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

## EXPENSE LIMITS

### Recommended Coding

- Local Travel – Staff - 62410000
  - Staff Local Travel – Taxi – 62410001
  - Staff Travel – UNA – 62410002
  - Staff Provincial Travel – 62412000 (all expenses)
  - Staff Out of Province Travel – 62414000 (all expenses)
- Catering – 69600000
  - Meals - 62410000
  - Mileage – 62410000
  - Course Registration & Materials – 61030000

Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
April 2007	Mileage & Parking				\$50.95		111
May 2007	Mileage and Parking						104
June 2007	Mileage and Parking				4.00		66
<b>Total km</b>							281
<b>Rate as outlined in Section 2 – Travel below @</b>							.43
<b>Totals</b>					\$54.95		\$120.83

### EXPENSE LIMITS

- Meal Allowances**  
 When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:  
 Breakfast \$8.50 (if the departure time is earlier or the return time is later than 7:30 a.m.)  
 Lunch \$10.75 (if the departure time is earlier or the return time is later than 1:00 p.m.)  
 Dinner \$19.20 (if the departure time is earlier or the return time is later than 6:30 p.m.)  
 For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.  
 Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.
- Travel**
  - Use of personal automobile -- From March 1, 2006, reimbursement at the general rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
  - Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
  - Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
    - Monthly travel in excess of 340 kilometers; or
    - Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
    - Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
  - If union contract rate differs from \$0.43 then contract rate must be used.
  - Includes all forms of transportation costs, including taxis and buses for local travel.
  - Driving to and from work is not considered business travel and cannot be claimed.
- Advance**  
 Travel advance may be requested provided travel expenses are likely to exceed \$500.

APPLICANT COPY



MILEAGE AND PARKING CLAIM FORM (WITHIN REGION)

Program <i>EXEC</i>	Employee Name <i>Glenda Coleman-Miller</i>	Location <i>RAH</i>	Payroll #
------------------------	---	------------------------	-----------

s.17(1), 17(4)(g)(i)

NOTE: 1) It is the employee's responsibility to maintain adequate records to substantiate all mileage claims to Revenue Canada, Program Management, or Finance upon request. You must be able to provide documentation which shows the date, destination and km travelled on each of your trips.  
2) Driving to and from work is not considered business travel and must not be claimed.

Month <i>April</i>	Year <i>2007</i>
-----------------------	---------------------

Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	Date	KM	Parking
1			9			17	16	4.05	25		
2			10		54.00 (TAX)	18			26		
3	16	6.00	11			19			27		
4			12	16	4.50	20			28		
5	14	7.00	13			21			29		
6			14			22			30		
7			15			23	16	5.40	31		
8			16	16	3.00	24	15				
									Total	111	50.95

Declaration: I hereby certify that the mileage and parking charges listed above were incurred on Capital Health business and that the amount has not been previously claimed by me or on my behalf.

APPLICANT COPY



**MILEAGE AND PARKING CLAIM FORM (WITHIN REGION)**

Program <i>EXEC</i>	Employee Name <i>Glenda Coleman-Miller</i>	Location <i>RAT</i>	Payroll #
------------------------	---	------------------------	-----------

NOTE: 1) It is the employee's responsibility to maintain adequate records to substantiate all mileage claims to Revenue Canada, Program Management, or Finance upon request. You must be able to provide documentation which shows the date, destination and km travelled on each of your trips. s.17(1), 17(4)(g)(i)  
 2) Driving to and from work is not considered business travel and must not be claimed.

Month <i>May</i>	Year <i>2007</i>
---------------------	---------------------

Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	Date	KM	Parking
1			9			17			25		
2			10	<i>22</i>		18			26		
3	<i>6</i>		11			19			27		
4	<i>6</i>		12			20			28	<i>16</i>	
5			13			21			29		
6			14	<i>16</i>		22			30		
7			15	<i>16</i>		23			31		
8	<i>16</i>		16	<i>6</i>		24			Total <i>104</i>		

Declaration: I hereby certify that the mileage and parking charges listed above were incurred on Capital Health business and that the amount has not been previously claimed by me or on my behalf.



APPLICANT COPY

**MILEAGE AND PARKING CLAIM FORM (WITHIN REGION)**

Program <i>EXEC</i>	Employee Name <i>Glenda Coleman-Miller</i>	Location <i>RAH</i>	Payroll #
------------------------	---	------------------------	-----------

NOTE: 1) It is the employee's responsibility to maintain adequate records to substantiate all mileage claims to Revenue Canada, Program Management, or Finance upon request. You must be able to provide documentation which shows the date, destination and km travelled on each of your trips. s.17(1), 17(4)(g)(i)

2) Driving to and from work is not considered business travel and must not be claimed.

Month <i>June</i>	Year <i>2007</i>
----------------------	---------------------

Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	Date	KM	Parking
1			9			17			25		
2			10			18			26		
3			11	<i>6</i>		19			27		
4			12	<i>16</i>	<i>4.00</i>	20			28	<i>6</i>	
5			13			21			29	<i>16</i>	
6			14	<i>22</i>		22			30		
7			15			23			31		
8			16			24					
									Total <i>66</i> <i>4.00</i>		

Declaration: I hereby certify that the mileage and parking charges listed above were incurred on Capital Health business and that the amount has not been previously claimed by me or on my behalf.



UNIVERSITY OF ALBERTA  
 HOSPITAL 83 AVE  
 THANK YOU FOR PARKING  
**Best Copy Possible**

Receipt 19510  
 04/05/07 15:26 LH 1 AH 3 TKN# 71147  
 04/05/07 12:58 In 04/05/07 15:26 Out  
 TKN# 072410  
 Daily Rate \$ 7.00  
 Total Fee \$ 7.00  
 CASH PAID \$ 7.00-  
 Cash Tender \$ 10.00  
 Change Due \$ 3.00

**Best Copy Possible**

UNIVERSITY OF ALBERTA  
 HOSPITAL 83 AVE  
 THANK YOU FOR PARKING

**Best Copy Possible**

UNIVERSITY OF ALBERTA  
 HOSPITAL 83 AVE  
 THANK YOU FOR PARKING

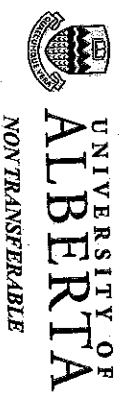
APPLICANT COPY

DISPLAY THIS SIDE UP ON DASHBOARD

EXPIRATION DATE  
**23/04/04:57 PM**  
 AMOUNT PAID  
**\$ 5.40 2409000002:57 PM**

DETACH RECEIPT FROM TICKET

DATE ISSUED TIME ISSUED AMOUNT PAID  
**23/04/07 02:57 PM \$ 5.40**  
 CREDIT CARD NUMBER  
 s.17(1), 17(4)(e.1)



UNIVERSITY OF ALBERTA  
 HOSPITAL 83 AVE  
 THANK YOU FOR PARKING  
**Best Copy Possible**

Receipt 19510  
 04/05/07 15:26 LH 1 AH 3 TKN# 71147  
 04/05/07 12:58 In 04/05/07 15:26 Out  
 TKN# 072410  
 Daily Rate \$ 7.00  
 Total Fee \$ 7.00  
 CASH PAID \$ 7.00-  
 Cash Tender \$ 10.00  
 Change Due \$ 3.00

AMOUNT PAID  
**\$ 4.05 2409000005:44 PM**  
 EXPIRATION DATE  
**12/04/07 05:44 PM**  
 DISPLAY THIS SIDE UP ON DASHBOARD

UNIVERSITY OF ALBERTA  
 HOSPITAL 83 AVE  
 THANK YOU FOR PARKING

UNIVERSITY OF ALBERTA  
 HOSPITAL 83 AVE  
 THANK YOU FOR PARKING

UNIVERSITY OF ALBERTA  
 HOSPITAL 83 AVE  
 THANK YOU FOR PARKING

DETACH #6  
 RECEIPT  
 UNIVERSITY OF ALBERTA  
 HOSPITAL 83 AVE  
 THANK YOU FOR PARKING

AMOUNT PAID  
**\$ 5.17(1), 17(4)(e.1)**  
 CREDIT CARD NUMBER  
 s.17(1), 17(4)(e.1)

REGISTRATION NUMBER: 10/06/07 04:02 PM \$ 3.00  
 DATE ISSUED: 10/06/07 04:02 PM \$ 3.00  
 TIME ISSUED: 10/06/07 04:02 PM \$ 3.00  
 AMOUNT PAID: 10/06/07 04:02 PM \$ 3.00  
 CREDIT CARD NUMBER: 10/06/07 04:02 PM \$ 3.00  
 DETACH RECEIPT FROM TICKET  
 Registered Dealer  
 John  
 Alex

EXPIRATION DATE: 12/06/06 06:09 PM  
 EXPIRATION TIME: 12/06/06 06:09 PM  
 AMOUNT PAID: 12/06/06 06:09 PM \$ 4.00  
 DISPLAY THIS SIDE UP ON DASHBOARD

**CHECKER**

Date: Apr 11 10/1/07 Amount: 12.00  
 Driver: \_\_\_\_\_ Car #: \_\_\_\_\_  
 From: \_\_\_\_\_ To: \_\_\_\_\_

(780) 484-8888  
 10135 - 31 Avenue  
 Edmonton, Alberta T6N 1C2  
 GST# 100403070

**YELLOW CAR**

Date: 10-04-07 Amount: 12.00  
 Driver: \_\_\_\_\_ Car #: 293  
 From: \_\_\_\_\_ To: \_\_\_\_\_

(780) 462-3456  
 10135 - 31 Avenue  
 Edmonton, Alberta T6N 1C2  
 GST# 100403070

UNIVERSITY OF ALBERTA  
 UNIVERSITY OF ALBERTA  
 RECEIPT  
 GST # R108102831

REGISTRATION NUMBER: 12/06/06 06:09 PM \$ 4.00  
 DATE ISSUED: 12/06/06 06:09 PM \$ 4.00  
 TIME ISSUED: 12/06/06 06:09 PM \$ 4.00  
 AMOUNT PAID: 12/06/06 06:09 PM \$ 4.00  
 CREDIT CARD NUMBER: 12/06/06 06:09 PM \$ 4.00  
 DETACH RECEIPT FROM TICKET

UNIVERSITY OF ALBERTA  
 UNIVERSITY OF ALBERTA  
 NON TRANSFERABLE

EXPIRATION DATE: 12/06/06 06:09 PM  
 EXPIRATION TIME: 12/06/06 06:09 PM  
 AMOUNT PAID: 12/06/06 06:09 PM \$ 4.00  
 DISPLAY THIS SIDE UP ON DASHBOARD



# APPLICANT COPY

## Travel & Employee Expense Claim Form

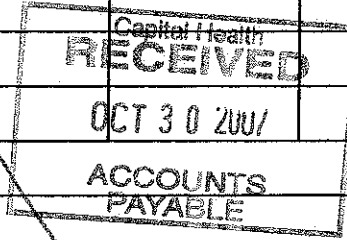
(In Canadian Dollars)

s.17(1), 17(4)(g)(i)

Name: Glenda Coleman-Miller	Employee Number:	Union Name:
Position: Senior Operating Officer	Department: Exec	
Business Phone: 735-5271	Period From: October 23/07 to October 23/07	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included	
201	0002	71110101001	69500000			\$2,400.84	<input checked="" type="checkbox"/>	
			6230000000				<input type="checkbox"/>	
							<input type="checkbox"/>	
							<input type="checkbox"/>	
							<input type="checkbox"/>	
							<input type="checkbox"/>	
Less Cash Advance							<input type="checkbox"/>	
<b>Total</b>							\$2,400.84	<input checked="" type="checkbox"/>



The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: *Glenda Coleman-Miller* Date: October 24, 2007

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: Joanna Pawlyshyn (Print name)	Title: V.P. & C.O.O.	Phone # 735-4101
(Signature) <i>[Signature]</i>	26 OCT 07	Date
Approved By:	Title:	Phone #
(Signature) <i>[Signature]</i>	RB	Date

### NOTE:

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
- GST amounts included in the expense claims will be calculated by Accounts Payable.
- Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
- For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
- For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
- See page 2 of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

**APPLICANT COPY**  
**EXPENSE CLAIM DETAILS**

<b>Recommended Coding</b>							
<ul style="list-style-type: none"> <li>• Local Travel – Staff - 62410000</li> <li>• Staff Local Travel – Taxi – 62410001</li> <li>• Staff Travel – UNA – 62410002</li> <li>• Staff Provincial Travel – 62412000 (all expenses)</li> <li>• Staff Out of Province Travel – 62414000 (all expenses)</li> </ul>				<ul style="list-style-type: none"> <li>• Catering – 69600000</li> <li>• Meals - 62410000</li> <li>• Mileage – 62410000</li> <li>• Course Registration &amp; Materials – 61030000</li> </ul>			
Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
Oct. 23/07	farewell Dinner for Gail Aguilon - 22 staff in attendance		\$2,400.84				
	<i>- RAN Operations Council</i>						
						<b>Total km</b>	
						<b>Rate as outlined in Section 2 – Travel below @</b>	
<b>Totals</b>			2400.84				

**EXPENSE LIMITS**

**1. Meal Allowances**

When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:

- Breakfast    \$8.50 (if the departure time is earlier or the return time is later than 7:30 a.m.)
- Lunch        \$10.75 (if the departure time is earlier or the return time is later than 1:00 p.m.)
- Dinner      \$19.20 (if the departure time is earlier or the return time is later than 6:30 p.m.)

For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.

Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.

**2. Travel**

- Use of personal automobile – From March 1, 2006, reimbursement at the general rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
- Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
- Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
  - 1. Monthly travel in excess of 340 kilometers; or
  - 2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
  - 3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
- If union contract rate differs from \$0.43 then contract rate must be used.
- Includes all forms of transportation costs, including taxis and buses for local travel.
- Driving to and from work is not considered business travel and cannot be claimed.

**3. Advance**

Travel advance may be requested provided travel expenses are likely to exceed \$500.

APPLICANT COPY

*Paul Caplinger*

CHARACTERS REST  
10257 - 105 STREET  
EDMONTON, AB.

TSJ 1E3

780-421-4100

GST# 89206-4429

Oct23'07 09:17PM

Date: Oct23'07 09:17PM  
Card Type: VISA

Acct #: 080830

Exp Date: 4014

Auth Code: 102/1

Check: 113 spare s

Table: 113 spare s

Server: G COLEMAN MILLER

Subtotal: 2375.84

GRATUITY 35.00

TOTAL 2400.84

SIGNATURE  
\*\* Customer Copy \*\*

s.17(1), 17(4)(e.1)

CHARACTERS REST  
10257 - 105 Street  
EDMONTON, AB.  
TSJ 1E3  
(780) 421-4100  
GST# 89206-4429

113 spare s

Tbl 102/1 Chk 4014 Gst 22  
Oct23'07 07:43PM

- 22 @ 66.00 SET MENU \$66 1452.00
- 1 1GL.gnarley dude 14.00
- 2 @ 8.50 1GL.FACELLI FUME 17.00
- 4 @ 65.00 B. gnarley dudes 260.00
- 2 B.CHABLIS @ 48.00 96.00
- 4 HSE WH RUM @ 5.50 22.00
- 6 POP @ 2.75 16.50
- 7 COFFEE @ 2.75 19.25
- 5 DECAF @ 2.75 13.75
- 2 TEA @ 2.75 5.50

18% Gratuity 344.88

Subtotal 1915.00  
Service Chrg 344.88  
GST 114.96  
09:15 Amount D 2375.84

WELCOME TO CHARACTERS!  
& HAVE A GREAT DAY!!



APPLICANT COPY

Travel approved  
Calgary

Travel & Employee Expense Claim Form

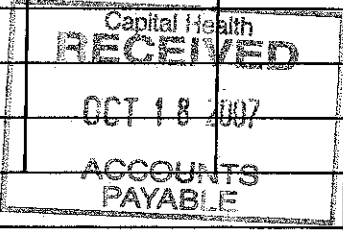
(In Canadian Dollars)  
s.17(1), 17(4)(g)(i)

Name: Glenda Coleman-Miller	Employee Number:	Union Name:
Position: Senior Operating Officer	Department: Exec	
Business Phone: 735-5271	Period From: October 3 to October 4 <sup>th</sup> , 2007	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0002	71110101001	62312000			\$154.43	<input checked="" type="checkbox"/>
201	0002	71110101001	6232000			258.00	<input checked="" type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
Total						\$412.43	<input type="checkbox"/>

5.62 NT  
406.81 T



The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: <i>Glenda Coleman-Miller</i>	Date: <i>October 10/07</i>
--	----------------------------

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: Joanna Pawlyshyn (Print name)	Title: V.P. & C.O.O.	Phone # 735-4101
(Signature) <i>[Signature]</i>	<i>11/2/07</i>	Date
Approved By:	Title:	Phone #
(Signature)		Date

NOTE:

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
- GST amounts included in the expense claims will be calculated by Accounts Payable.
- Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
- For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
- For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
- See page 2 of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

<b>Recommended Coding</b>							
<ul style="list-style-type: none"> <li>• Local Travel – Staff - 62410000</li> <li>• Staff Local Travel – Taxi – 62410001</li> <li>• Staff Travel – UNA – 62410002</li> <li>• Staff Provincial Travel – 62412000 (all expenses)</li> <li>• Staff Out of Province Travel – 62414000 (all expenses)</li> </ul>				<ul style="list-style-type: none"> <li>• Catering – 69600000</li> <li>• Meals - 62410000</li> <li>• Mileage – 62410000</li> <li>• Course Registration &amp; Materials – 61030000</li> </ul>			
Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
October 3rd	ACEN Meeting - Calgary						600
October 3rd	ACEN Meeting - Calgary	154.43					
<b>Total km</b>							600
<b>Rate as outlined in Section 2 – Travel below @</b>							0
<b>Totals</b>		\$154.43					\$258.00

**EXPENSE LIMITS**

- 1. Meal Allowances**  
 When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:  
 Breakfast     \$8.50 (if the departure time is earlier or the return time is later than 7:30 a.m.)  
 Lunch           \$10.75 (if the departure time is earlier or the return time is later than 1:00 p.m.)  
 Dinner          \$19.20 (if the departure time is earlier or the return time is later than 6:30 p.m.)  
 For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.  
 Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.
- 2. Travel**
  - Use of personal automobile – From March 1, 2006, reimbursement at the general rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
  - Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
  - Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
    1. Monthly travel in excess of 340 kilometers; or
    2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
    3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
  - If union contract rate differs from \$0.43 then contract rate must be used.
  - Includes all forms of transportation costs, including taxis and buses for local travel.
  - Driving to and from work is not considered business travel and cannot be claimed.
- 3. Advance**  
 Travel advance may be requested provided travel expenses are likely to exceed \$500.



135 Southland Drive S.E.  
 Calgary, Alberta T2J 5X5  
 Phone: (403) 278-5059 Fax: (403) 225-5834  
 Toll Free Reservations 1-(877) 278-5050  
 Email: info@deltacalgarysouth.com  
 Web address: www.deltacalgarysouth.com

APPLICANT COPY G.S.T. NO. 895126332 RT

*ACEN  
 meeting  
 in Calgary*

Room : 0805  
 Folio # :  
 Cashier # : 162  
 Page # : 1 of 1

**Capital Health**  
**Glenda Coleman-Miller**  
**Royal Alexandra Hospital**  
**Edmonton, AB T5H 3V9**  
**CA**

Arrival : 10-03-07  
 Departure : 10-04-07

	Description	Additional Information	Charges	Credits
10-03-07	Room Charge		139.00	
10-03-07	DMF		1.39	
10-03-07	Room GST		8.42	
10-03-07	Tourism Levy		5.62	
<b>Total</b>			<b>154.43</b>	<b>0.00</b>
<b>Balance Due</b>			<b>154.43</b>	

G.S.T. Summary

Room	8.42
F&B	0.00
Other	0.00
Total	0.00

Guest Signature X \_\_\_\_\_

I have accepted delivery of The Globe and Mail. Had I refused, I would have been eligible for a \$.75 (Mon-Fri) and \$1.50 (Sat.) credit to my account. (At participating hotels.)

Regardless of charge instructions, I acknowledge the above as personal indebtedness.

E.&OE.





# APPLICANT COPY

## Travel & Employee Expense Claim Form

(In Canadian Dollars)

s.17(1), 17(4)(g)(i)

Name: Glenda Coleman-Miller	Employee Number:	Union Name:
Position: Senior Operating Officer	Department: RAH - Exec	
Business Phone: 735-5271	Period From: July 2007 to October 2007	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0002	71110101001	62310000			\$64.25	<input checked="" type="checkbox"/>
201	0002	71110101001	62310000			94.17	<input checked="" type="checkbox"/>
201	0002	71110101001	69500007			24.33	<input checked="" type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
Total							<input type="checkbox"/>

Capital Health  
**RECEIVED**  
DEC 04 2007 \$182.75  
ACCOUNTS  
PAYABLE

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: *GC* Date: November 15, 2007

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: Joanna Pawlyshyn (Print name)	Title: V.P. & C.O.O.	Phone # 735-4101
(Signature) <i>[Signature]</i>	21 NOV 07	Date
Approved By:	Title:	Phone #
(Signature)		Date

### NOTE:

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
- GST amounts included in the expense claims will be calculated by Accounts Payable.
- Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
- For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
- For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
- See page 2 of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

sent to  
A/P 11/22/07

**APPLICANT GORY**  
EXPENSE CLAIM DETAILS

**Recommended Coding**

- Local Travel – Staff - 62410000
- Staff Local Travel – Taxi – 62410001
- Staff Travel – UNA – 62410002
- Staff Provincial Travel – 62412000 (all expenses)
- Staff Out of Province Travel – 62414000 (all expenses)
- Catering – 69600000
- Meals - 62410000
- Mileage – 62410000
- Course Registration & Materials – 61030000

Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
July 2007	Mileage & Parking				\$6.00		34
Aug. 2007	Mileage and Parking				4.00		38
Sept. 2007	Mileage and Parking				27.50		77
Oct. 2007	Mileage and Parking				26.75		70
July 8, 2007	Gift for D. Paulson - Committee Work					24.33	
<b>Total km</b>							219
<b>Rate as outlined in Section 2 – Travel below @</b>							.43
<b>Totals</b>					\$64.25	24.33	\$94.17

**EXPENSE LIMITS**

**1. Meal Allowances**

When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:

- Breakfast \$8.50 (if the departure time is earlier or the return time is later than 7:30 a.m.)
- Lunch \$10.75 (if the departure time is earlier or the return time is later than 1:00 p.m.)
- Dinner \$19.20 (if the departure time is earlier or the return time is later than 6:30 p.m.)

For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.

Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.

**2. Travel**

- Use of personal automobile – From March 1, 2006, reimbursement at the general rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
- Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
- Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
  - 1. Monthly travel in excess of 340 kilometers; or
  - 2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
  - 3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
- If union contract rate differs from \$0.43 then contract rate must be used.
- Includes all forms of transportation costs, including taxis and buses for local travel.
- Driving to and from work is not considered business travel and cannot be claimed.

**3. Advance**

Travel advance may be requested provided travel expenses are likely to exceed \$500.

APPLICANT COPY

*Gift for*  
*Thank you*  
8/9/2007 1:15  
Trans:7451

*canon*  
*inclusion of*  
*work on*  
*ed by*  
GK #203330  
1:03000027-538002

=====  
Transaction  
Cardy  
K  
Edme

*Receipt*  
=====  
# 635  
AB

TYPE: PURCHASE

ACCT: CHEQUIN

CARD NUMBER:

DATE/TIME: 01/18/09

REFERENCE #: 600459

AUTHOR. #: 003 32

s.17(1), 17(4)(e.1)

11  
15170 S

00 APPROVED - BANK

APPLICANT COPY



MILEAGE AND PARKING CLAIM FORM (WITHIN REGION)

Program <i>EXEC</i>	Employee Name <i>Glenda Coleman-Miller</i>	Location <i>RAH</i>	Payroll #
------------------------	---	------------------------	-----------

NOTE: 1) It is the employee's responsibility to maintain adequate records to substantiate all mileage claims to Revenue Canada, Program Management, or Finance upon request. You must be able to provide documentation which shows the date, destination and km travelled on each of your trips. s.17(1), 17(4)(g)(i)  
 2) Driving to and from work is not considered business travel and must not be claimed.

Month <i>JULY</i>	Year <i>2007</i>
----------------------	---------------------

Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	Date	KM	Parking
1			9			17			25		
2			10			18	<i>12</i>		26		
3			11			19			27		
4			12	<i>16</i>		20	<i>6</i>	<i>6.00</i>	28		
5			13			21			29		
6			14			22			30		
7			15			23			31		
8			16			24					
						Total		<i>34</i>	<i>6.00</i>		

Declaration: I hereby certify that the mileage and parking charges listed above were incurred on Capital Health business and that the amount has not been previously claimed by me or on my behalf.



APPLICANT COPY

MILEAGE AND PARKING CLAIM FORM (WITHIN REGION)

Program <i>EXEC</i>	Employee Name <i>Glenda Coleman-Miller</i>	Location <i>RAH</i>	Payroll #
------------------------	---	------------------------	-----------

NOTE: 1) It is the employee's responsibility to maintain adequate records to substantiate all mileage claims to Revenue Canada, Program Management, or Finance upon request. You must be able to provide documentation which shows the date, destination and km travelled on each of your trips. s.17(1), 17(4)(g)(i)

2) Driving to and from work is not considered business travel and must not be claimed.

Month <i>August</i>	Year <i>2007</i>
------------------------	---------------------

Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	Date	KM	Parking
1			9			17			25		
2	<i>16</i>		10			18			26		
3			11			19			27		
4			12			20			28		
5			13			21			29		
6			14			22			30		
7			15	<i>16</i>		23	<i>6</i>	<i>4.00</i>	31		
8			16			24					
Total						<i>38</i>		<i>4.00</i>			

Declaration: I hereby certify that the mileage and parking charges listed above were incurred on Capital Health business and that the amount has not been previously claimed by me or on my behalf.

TICKET VOID IF R  
CUT VOID IF RE-SOLD



IMPARK

PLACE THIS SIDE UP ON DASH

Hourly Parker

Meter: 02026501  
Trans: 000477  
Time: 2:54P AUG 23  
Price: \$ 4.00  
Expires:

PLACE THIS SIDE UP ON DASH

3:54PM THU  
AUG 23 07

INSTRUCTIONS ON BACK  
Please remember the  
arkade use @ 9pm



APPLICANT COPY



MILEAGE AND PARKING CLAIM FORM (WITHIN REGION)

Program <i>EXEC</i>	Employee Name <i>Glenda Coleman-Muller</i>	Location <i>RAH</i>	Payroll #
------------------------	---	------------------------	-----------

NOTE: 1) It is the employee's responsibility to maintain adequate records to substantiate all mileage claims to Revenue Canada, Program Management, or Finance upon request. You must be able to provide documentation which shows the date, destination and km travelled on each of your trips. s.17(1), 17(4)(g)(i)

2) Driving to and from work is not considered business travel and must not be claimed.

Month <i>Sept</i>	Year <i>2007</i>
----------------------	---------------------

Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	
1			9			17	<i>CAB</i>	<i>30.00</i>	25			
2			10			18	<i>16</i>		26			
3			11			19	<i>7</i>	<i>7.50</i>	27			
4			12			20	<i>16</i>		28			
5			13	<i>16</i>		21	<i>16</i>		29			
6			14	<i>4</i>		22			30			
7			15			23			31			
8			16			24						
										Total	<i>77</i>	<i>27.50</i>

Declaration: I hereby certify that the mileage and parking charges listed above were incurred on Capital Health business and that the amount has not been previously claimed by me or on my behalf.

APPLICANT COPY

**YELLOW CAB**

**(780) 462-3456**

10135 - 31 Avenue  
Edmonton, Alberta T6N 1C2

GST# 100403070

Date: 17 07-07 Amount: 20.00  
Driver: MAZON Car #: 286  
From: \_\_\_\_\_ To: \_\_\_\_\_

**DISPLAY FACE UP ON DASH RECEIPT**

**Impark Lot 002-256**  
EDMONTON, AB. 780-420-1976  
GST #88731 5638 FT0001  
Machine Serial #: 000005071052

**EXPIRY DATE AND TIME**

**EXP 11:50am**  
**SEP 19, 2007**

TICKET# **0059167** LOT# **00020256**

CC: \$0007.50 Visa MACH# 001  
FOLLOW INSTRUCTIONS ON SIGNS POSTED

EXP 11:50am  
SEP 19, 2007  
CC  
LOT# 00020256  
MACH# 001  
TICK# 00059167  
CC: \$0007.50  
SEP 19, 2007  
10:23am  
Purchase Time

s.17(1), 17(4)(e.1)  
**Park 1 1/2 Hr \$7.50**

Pay from your cell phone.  
423-1922 Location 9804.  
Go to [www.ImparkWireless.com](http://www.ImparkWireless.com)

**DISPLAY FACE UP ON DASH RECEIPT**

s.17(1), 17(4)(e.1)





APPLICANT COPY

MILEAGE AND PARKING CLAIM FORM (WITHIN REGION)

Program <i>EXEC</i>	Employee Name <i>Glenda Coleman-Miller</i>	Location <i>RAH</i>	Payroll #
------------------------	---	------------------------	-----------

NOTE: 1) It is the employee's responsibility to maintain adequate records to substantiate all mileage claims to Revenue Canada, Program Management, or Finance upon request. You must be able to provide documentation which shows the date, destination and km travelled on each of your trips. s.17(1), 17(4)(g)(i)

2) Driving to and from work is not considered business travel and must not be claimed.

Month <i>October</i>	Year <i>2007</i>
-------------------------	---------------------

Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	
1			9			17			25	/	15 <sup>00</sup>	
2			10			18			26			
3			11			19	6		27			
4			12			20			28			
5			13			21			29			
6			14			22			30	16		
7			15			23	14	8 <sup>00</sup>	31	14		
8			16			24	16	3 <sup>75</sup>				
										Total	70	26.75

Declaration: I hereby certify that the mileage and parking charges listed above were incurred on Capital Health business and that the amount has not been previously claimed by me or on my behalf.

APPLICANT COPY.

DISPLAY THIS SIDE UP ON DASHBOARD

EXPIRATION DATE

EXPIRATION TIME

12/24/10 06:45 AM

AMOUNT PAID

\$ 3.75 152100000 04:42 PM



UNIVERSITY OF ALBERTA

1095342

NON TRANSFERABLE

*Membership Awards*

DETACH RECEIPT FROM TICKET

DATE ISSUED

TIME ISSUED

AMOUNT PAID

23/10/07 04:42 PM \$ 3.75

CREDIT CARD NUMBER

s.17(1), 17(4)(e.1)



UNIVERSITY OF ALBERTA

1095342

RECEIPT

GST # R108102831

Name \_\_\_\_\_

Amount Pd: *\$ 15.29*

Licence \_\_\_\_\_ Prdv. \_\_\_\_\_

Make \_\_\_\_\_ Color \_\_\_\_\_

Date \_\_\_\_\_

*QEM S meeting No 2,743*

(780) 462-3456

10135-31 Avenue  
Edmonton, Alberta T6N 1C2

GST# 100-403070

**YELLOW CAB**

Date: *Oct 25/07* Amount: *15.29*  
Driver: *R.A.H.* Cat #: *257*  
To: *U-0A*

APPLICANT COPY

**Laraque (Savage), Aileen**

---

**From:** Barlow, Kathy  
**Sent:** Friday, November 30, 2007 2:04 PM  
**To:** Laraque (Savage), Aileen  
**Subject:** COLEMAN MILLER, GLENDA

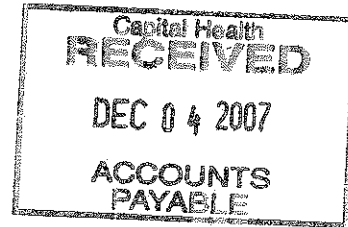
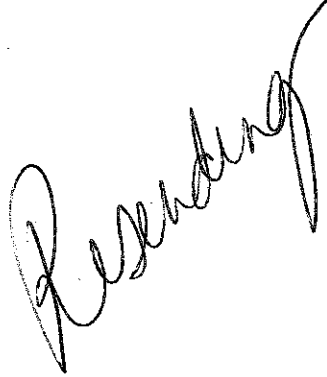
**Follow Up Flag:** Follow up  
**Flag Status:** Red

Hi Aileen,

Just to keep you informed that I cannot process Glenda's expense of 182.75 because she is claiming 64.25 for parking and we have no receipts attached, As per policy we should have these receipts. Thanks

**Kathy Barlow**

Capital Health  
Accounts Payable  
Phone: 780-735-0474  
Fax: 780-735-0508





Misses Patric  
Receiv

APPLICANT COPY

Travel & Employee Expense Claim Form

(In Canadian Dollars)

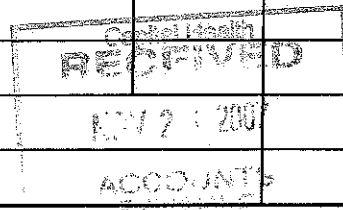
s.17(1), 17(4)(g)(i)

Name: Glenda Coleman-Miller	Employee Number	Union Name:
Position: Senior Operating Officer	Department: RAH - Exec	
Business Phone: 735-5271	Period From: July 2007 to October 2007	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0002	71110101001	62310000			\$64.25	<input checked="" type="checkbox"/>
201	0002	71110101001	62310000			94.17	<input checked="" type="checkbox"/>
201	0002	71110101001	69500007			24.33	<input checked="" type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
<b>Total</b>						\$182.75	<input type="checkbox"/>

Please Note they sent an email was your BR



The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: *ECM*

Date: November 15, 2007

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: Joanna Pawlyshyn (Print name)	Title: V.P. & C.O.O.	Phone # 735-4101
(Signature)	21 NOV 07	Date
Approved By:	Title:	Phone #
(Signature)		Date

NOTE:

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
- GST amounts included in the expense claims will be calculated by Accounts Payable.
- Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
- For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
- For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
- See page 2 of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

**APPLICANT COPY**  
**EXPENSE CLAIM DETAILS**

<b>Recommended Coding</b>							
<ul style="list-style-type: none"> <li>• Local Travel – Staff - 62410000</li> <li>• Staff Local Travel – Taxi – 62410001</li> <li>• Staff Travel – UNA – 62410002</li> <li>• Staff Provincial Travel – 62412000 (all expenses)</li> <li>• Staff Out of Province Travel – 62414000 (all expenses)</li> </ul>				<ul style="list-style-type: none"> <li>• Catering – 69600000</li> <li>• Meals - 62410000</li> <li>• Mileage – 62410000</li> <li>• Course Registration &amp; Materials – 61030000</li> </ul>			
Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
July 2007	Mileage & Parking				\$6.00		34
Aug. 2007	Mileage and Parking				4.00		38
Sept. 2007	Mileage and Parking				27.50		77
Oct. 2007	Mileage and Parking				26.75		70
July 8, 2007	Gift for D. Paulson - Committee Work					24.33	
<b>Total km</b>							219
<b>Rate as outlined in Section 2 – Travel below @</b>							.43
<b>Totals</b>					\$64.25	24.33	\$94.17

**EXPENSE LIMITS**

- 1. Meal Allowances**  
 When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:
  - Breakfast      \$8.50 (if the departure time is earlier or the return time is later than 7:30 a.m.)
  - Lunch          \$10.75 (if the departure time is earlier or the return time is later than 1:00 p.m.)
  - Dinner         \$19.20 (if the departure time is earlier or the return time is later than 6:30 p.m.)
 For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.  
 Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.
  
- 2. Travel**
  - Use of personal automobile – From March 1, 2006, reimbursement at the general rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
  - Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
  - Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
    1. Monthly travel in excess of 340 kilometers; or
    2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
    3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
  - If union contract rate differs from \$0.43 then contract rate must be used.
  - Includes all forms of transportation costs, including taxis and buses for local travel.
  - Driving to and from work is not considered business travel and cannot be claimed.
  
- 3. Advance**  
 Travel advance may be requested provided travel expenses are likely to exceed \$500.

APPLICANT COPY

**Barlow, Kathy**

---

**From:** Barlow, Kathy  
**Sent:** Friday, November 30, 2007 2:04 PM  
**To:** Laraque (Savage), Aileen  
**Subject:** COLEMAN MILLER, GLENDA

Hi Aileen,  
Just to keep you informed that I cannot process Glenda's expense of 182.75 because she is claiming 64.25 for parking and we have no receipts attached, As per policy we should have these receipts. Thanks

**Kathy Barlow**  
Capital Health  
Accounts Payable  
Phone: 780-735-0474  
Fax: 780-735-0508

*Gift for Glenna Paulson as  
thanks for work on  
Card Block*  
8/9/2007 1:08:15 PM Card Block #203330  
Trans:7451 Terminal:03000087-635002  
*Proposal*  
=====Transaction Receipt=====

Purdy's Store 635  
Kingsway  
Edmonton, AB

TYPE: PURCHASE

ACCT: CHEQUING \$ 24.33

CARD NUMBER: s.17(1), 17(4)(e.1)  
DATE/TIME: 07/08/09 13:15:11  
REFERENCE #: 66104594 0010015170 S  
AUTHOR. #: 003382

00 APPROVED - THANK YOU 001



APPLICANT COPY

### Travel & Employee Expense Claim Form

(In Canadian Dollars) s.17(1), 17(4)(g)(i)

<b>Name:</b> Glenda Coleman-Miller	<b>Employee Number:</b>	<b>Union Name:</b>
<b>Position:</b> Senior Operating Officer	<b>Department:</b> RAH - Executive	
<b>Business Phone:</b> 735-5271	<b>Period From:</b> Nov. 28th to December 6, 2007	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	9000	71110101001	62312000	2314		\$713.69	<input checked="" type="checkbox"/>
201	0002	71110101001	62312000			189.00	<input checked="" type="checkbox"/>
201	0002	71110101001	41030000			44.50	<input checked="" type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
<b>Less Cash Advance</b>							<input type="checkbox"/>
<b>Total</b>						\$947.19	<input checked="" type="checkbox"/>

Capital Health  
RECEIVED  
JAN 03 2008  
ACCOUNTS PAYABLE

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: *[Signature]* Date: December 11, 2007

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

<b>Approved By:</b> Joanna Pawlyshyn (Print name)	<b>Title:</b> V.P. and C.O.O.	<b>Phone #</b> 735-4101
(Signature)	02 JAN 08	<b>Date</b>
<b>Approved By:</b> (Print name)	<b>Title:</b>	<b>Phone #</b>
(Signature)		<b>Date</b>

- NOTE:**
- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
  - GST amounts included in the expense claims will be calculated by Accounts Payable.
  - Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
  - For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
  - For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
  - See page 2 of this form for expense claim limits.
  - Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
  - Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

Recommended Coding							
<ul style="list-style-type: none"> <li>Local Travel – Staff - 62410000</li> <li>Staff Local Travel – Taxi – 62410001</li> <li>Staff Travel – UNA – 62410002</li> <li>Staff Provincial Travel – 62412000 (all expenses)</li> <li>Staff Out of Province Travel – 62414000 (all expenses)</li> </ul>				<ul style="list-style-type: none"> <li>Catering – 69600000</li> <li>Meals - 62410000</li> <li>Mileage – 62410000</li> <li>Course Registration &amp; Materials – 61030000</li> </ul>			
Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
Nov. 28	Taxi to Edmonton International - ACEN Conference				\$50.00		
Nov. 28	Taxi - Airport Ottawa to Hotel - ACEN				29.00		
Nov. 28 - Dec. 1/07	Hotel - Ottawa - ACEN Conference	713.69					
Dec. 1/07	Taxi - Hotel in Ottawa to Airport - ACEN				30.00		
Dec. 1/07	Airport to hotel in Philadelphia (Wharton Course)				30.00		
Dec. 3/07	Printer Charges for Meeting Prep Material					44.50	
Dec. 6/07	Taxi - Edm. International to home				50.00		
						<b>Total km</b>	
<b>Rate as outlined in Section 2 – Travel below @</b>							
<b>Totals</b>		\$713.69			\$189.00	44.50	

**EXPENSE LIMITS**

**1. Meal Allowances**

When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:

- Breakfast     \$8.50 (if the departure time is earlier or the return time is later than 7:30 a.m.)
- Lunch         \$10.75 (if the departure time is earlier or the return time is later than 1:00 p.m.)
- Dinner        \$19.20 (if the departure time is earlier or the return time is later than 6:30 p.m.)

For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.

Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.

**2. Travel**

- Use of personal automobile -- From March 1, 2006, reimbursement at the general rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
- Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
- Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
  1. Monthly travel in excess of 340 kilometers; or
  2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
  3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
- If union contract rate differs from \$0.43 then contract rate must be used.
- Includes all forms of transportation costs, including taxis and buses for local travel.
- Driving to and from work is not considered business travel and cannot be claimed.



APPLICANT COPY



**CROWNE PLAZA®**

OTTAWA HOTEL

THE PLACE TO MEET.

Crowne Plaza Ottawa  
 101 rue Lyon St.  
 Ottawa, Ontario Canada K1R 5T9  
 tel (613) 237-3600  
 fax (613) 237-2351  
 www.crowneplaza.ca

Glenda Colman-Miller  
 s.17(1), 17(4)(g)(i)

A/R # :  
 Group / Groupe :  
 Invoice # :  
 Folio # : 269732  
 Reference # :  
 Page # : 1 of 2  
 Cashier / Caissier : 1407

Room / Chambre 2007  
 Arrival / Arrivée : 11-28-07  
 Departure / Départ : 12-01-07

www.crowneottawa.ca

Date	Description	Charges / Débits	Credits / Crédits
11-28-07	In Room Dining Dinner #2007 : CHECK #5025	21.12	
11-28-07	Accommodation	209.95	
11-28-07	Room PST Tax 5%	10.50	
11-28-07	Room GST Tax 6%	12.60	
11-28-07	Room DMF Fee	5.94	
11-28-07	GST on DMF	0.36	
11-29-07	Accommodation	209.95	
11-29-07	Room PST Tax 5%	10.50	
11-29-07	Room GST Tax 6%	12.60	
11-29-07	Room DMF Fee	5.94	
11-29-07	GST on DMF	0.36	
11-30-07	In Room Dining Dinner #2007 : CHECK #5124	20.12	
11-30-07	Accommodation	169.95	
11-30-07	Room PST Tax 5%	8.50	
11-30-07	Room GST Tax 6%	10.20	
11-30-07	Room DMF Fee	4.81	
11-30-07	GST on DMF	0.29	
11-30-07	Visa s.17(1), 17(4)(e.1)		713.69

Our Commitment to Your Privacy / Notre engagement à l'égard de votre vie privée  
 Please see reverse / S'il vous plaît consulter l'endos

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Glenda Colman-Miller  
 s.17(1), 17(4)(g)(i)

A/R # :  
 Group / Groupe :  
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 Page # : 2 of 2  
 Cashier / Caissier : 1407

Room / Chambre 2007  
 Arrival / Arrivée : 11-28-07  
 Departure / Départ : 12-01-07

www.crowneottawa.ca

Date	Description	Charges / Débits	Credits / Crédits
<b>Total</b>		<b>713.69</b>	<b>713.69</b>
<b>Balance</b>		<b>0.00</b>	

Room GST Tax	GST Tax 6% F	Room PST Tax	GST on DMF	Room DMF Fe
35.40	1.88	0.00	32.01	0.00
			1.01	0.00
			0.00	0.00
				16.69
				0.00

GST # 886827930

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

I have received the goods and / or services in the amount shown heron. I agree that my liability for this bill is not waived and agree to be held personally liable in the event that the indicated person, company, or association fails to pay for any part or the full amount of these charges. If a credit card charge, I further agree to perform the obligations set forth in the cardholder's agreement with the issuer.

Our Commitment to Your Privacy / Notre engagement à l'égard de votre vie privée  
 Please see reverse / S'il vous plaît consulter l'endos

APPLICANT COPY

Date: 12/03/07  
Time: 13:13  
Location: 0073\_2\_hilton\_penn  
GLENDA COLEMAN-MILLER

*printing off  
documents for  
teleconference re:  
mid year budget  
preparation*

Minutes Charged: 10

-----  
Total: \$4.90

Laser Printer  
Price Per Page: \$0.99  
Pages Printed: 40

-----  
Total: \$39.60

=====  
Total Charges: \$44.50  
=====

Thank you for using Cybershell Kiosk (949) 707-0399 a divi

30.07  
3.75

Cash to airport  
for pickup

RECEIPT / REÇU

Amount/Montant: 29.00      28 11 2007

From/De: AIRPORT

To/à: \_\_\_\_\_

Taxi #: 727      Driver/Chauffeur: Denise

Thank you / Merci

**PRESTIGE**  
CABS

(780) 462-4444

10135 - 31 Avenue  
Edmonton, Alberta T6N 1C2  
GST# 100403070

Date: Dec 6-7      Amount: 50.00

Driver: Maria      Car #: 990

From: Airport      To: \_\_\_\_\_

s.17(1), 17(4)(g)(i)

**PRESTIGE**  
CABS

(780) 462-4444

10135 - 31 Avenue  
Edmonton, Alberta T6N 1C2  
GST# 100403070

Date: Nov 28-07      Amount: 50.00

Driver: Maria      Car #: 990

From: \_\_\_\_\_      To: Airport

s.17(1), 17(4)(g)(i)

**BLUELINE**

Job # \_\_\_\_\_

RECEIPT FOR CAB FARE

Amount: \$1 30      Date: 1 Dec 07

From: Glendon plaza

To: Airport

Cab No. 467      Driver: HA

G.S.T. Included in meter fare





# APPLICANT COPY

## Travel & Employee Expense Claim Form

(In Canadian Dollars) s.17(1), 17(4)(g)(i)

Name: Glenda Coleman-Miller	Employee Number:	Union Name:
Position: Senior Operating Officer	Department: RAH - Exec	
Business Phone: 735-5271	Period From: November 2007 to January 2008	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0002	71110101001	62310000			\$85.00	<input checked="" type="checkbox"/>
201	0002	71110101001	62310000			95.46	<input checked="" type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
Total						\$180.46	<input type="checkbox"/>

Capital Health  
RECEIVED  
FEB 28 2008  
ACCOUNTS  
PAYABLE

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: *[Signature]*

Date: Feb. 26, 2008

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: Joanna Pawlystyn (Print name)	Title: V.P. & C.O.O.	Phone # 735-4101
(Signature) <i>[Signature]</i>	26 Feb 08	Date
Approved By:	Title:	Phone #
(Signature) <i>[Signature]</i>		Date

### NOTE:

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
- GST amounts included in the expense claims will be calculated by Accounts Payable.
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- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

**EXPENSE CLAIM ONLY**

**Recommended Coding**

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li>• Local Travel – Staff - 62410000</li> <li>• Staff Local Travel – Taxi – 62410001</li> <li>• Staff Travel – UNA – 62410002</li> <li>• Staff Provincial Travel – 62412000 (all expenses)</li> <li>• Staff Out of Province Travel – 62414000 (all expenses)</li> </ul> | <ul style="list-style-type: none"> <li>• Catering – 69600000</li> <li>• Meals - 62410000</li> <li>• Mileage – 62410000</li> <li>• Course Registration &amp; Materials – 61030000</li> </ul> |
|---|---|

Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
Nov. 07	Mileage & Parking				\$41.00		102
Dec. 07	Mileage and Parking				<del>15.00</del>		<del>54</del>
Jan. 08	Mileage and Parking				<del>28.40</del>		<del>66</del>
					85.00		
<b>Total km</b>							222
<b>Rate as outlined in Section 2 – Travel below @</b>							.43
<b>Totals</b>					\$85.00		\$95.46

**EXPENSE LIMITS**

**1. Meal Allowances**

When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:

- Breakfast \$8.50 (if the departure time is earlier or the return time is later than 7:30 a.m.)
- Lunch \$10.75 (if the departure time is earlier or the return time is later than 1:00 p.m.)
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**2. Travel**

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- Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
- Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
  1. Monthly travel in excess of 340 kilometers; or
  2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
  3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
- If union contract rate differs from \$0.43 then contract rate must be used.
- Includes all forms of transportation costs, including taxis and buses for local travel.
- Driving to and from work is not considered business travel and cannot be claimed.

**3. Advance**

Travel advance may be requested provided travel expenses are likely to exceed \$500.



APPLICANT COPY

MILEAGE AND PARKING CLAIM FORM (WITHIN REGION)

Program EXEC	Employee Name Glenda Coleman-Miller	Location RAH	Payroll #
-----------------	--	-----------------	-----------

s.17(1), 17(4)(g)(i)  
 NOTE: 1) It is the employee's responsibility to maintain adequate records to substantiate all mileage claims to Revenue Canada, Program Management, or Finance upon request. You must be able to provide documentation which shows the date, destination and km travelled on each of your trips.  
 2) Driving to and from work is not considered business travel and must not be claimed.

Month NOVEMBER	Year 2007
-------------------	--------------

Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	Date	KM	Parking
1			9	16	2.00	17			25		
2	16	12.00 (2)	10			18			26		
3			11			19			27		
4			12			20	16	2.75	28		
5	16	2.75	13	16	4.00	21	16	10.00	29		
6			14			22			30		
7			15	6	7.50	23			31		
8			16			24					
									Total	102	41.00

Declaration: I hereby certify that the mileage and parking charges listed above were incurred on Capital Health business and that the amount has not been previously claimed by me or on my behalf.

IMPACT FACILITY IMPACT FACILITY DASH RECEIPT  
 Impact Lot 002-256  
 EDMONTON AB 780-420-1976  
 GST # R38731 5638 FIT0001

IMPACT FACILITY IMPACT FACILITY DASH RECEIPT  
 Impact Lot 002-256  
 EDMONTON AB 780-420-1976  
 GST # R38731 5638 FIT0001

IMPACT FACILITY IMPACT FACILITY DASH RECEIPT  
 Impact Lot 002-256  
 EDMONTON AB 780-420-1976  
 GST # R38731 5638 FIT0001

NOV 21, 2007 11:22 AM  
 TICKET# 00067436 LOT# 00057436  
 CC \$000.00 Visa MCH# 001  
 PURCHASE TIME 13:58am  
 S.17(D), 17(4)(e-1)  
 Park 2 Hr. \$10.00

NOV 15, 2007 11:22 AM  
 TICKET# 00067436 LOT# 00057436  
 CC \$000.00 Visa MCH# 001  
 PURCHASE TIME 13:58am  
 S.17(D), 17(4)(e-1)  
 Park 1 1/2 Hr \$7.50

NOV 02, 2007 11:22 AM  
 TICKET# 00067436 LOT# 00057436  
 CC \$000.00 Visa MCH# 001  
 PURCHASE TIME 13:58am  
 S.17(D), 17(4)(e-1)  
 Park 1 1/2 Hr \$7.50

NOV 21, 2007 11:22 AM  
 TICKET# 00067436 LOT# 00057436  
 CC \$000.00 Visa MCH# 001  
 PURCHASE TIME 13:58am  
 S.17(D), 17(4)(e-1)  
 Park 2 Hr. \$10.00

NOV 15, 2007 11:22 AM  
 TICKET# 00067436 LOT# 00057436  
 CC \$000.00 Visa MCH# 001  
 PURCHASE TIME 13:58am  
 S.17(D), 17(4)(e-1)  
 Park 1 1/2 Hr \$7.50

NOV 02, 2007 11:22 AM  
 TICKET# 00067436 LOT# 00057436  
 CC \$000.00 Visa MCH# 001  
 PURCHASE TIME 13:58am  
 S.17(D), 17(4)(e-1)  
 Park 1 1/2 Hr \$7.50

NOV 21, 2007 11:22 AM  
 TICKET# 00067436 LOT# 00057436  
 CC \$000.00 Visa MCH# 001  
 PURCHASE TIME 13:58am  
 S.17(D), 17(4)(e-1)  
 Park 2 Hr. \$10.00

NOV 15, 2007 11:22 AM  
 TICKET# 00067436 LOT# 00057436  
 CC \$000.00 Visa MCH# 001  
 PURCHASE TIME 13:58am  
 S.17(D), 17(4)(e-1)  
 Park 1 1/2 Hr \$7.50

NOV 02, 2007 11:22 AM  
 TICKET# 00067436 LOT# 00057436  
 CC \$000.00 Visa MCH# 001  
 PURCHASE TIME 13:58am  
 S.17(D), 17(4)(e-1)  
 Park 1 1/2 Hr \$7.50

APPLICANT COPY

DISPLAY THIS SIDE UP ON DASHBOARD

EXPIRATION DATE

05/11 11:22 AM

AMOUNT PAID

\$ 2.75 240900000 10:21 AM



UNIVERSITY OF ALBERTA

1075152

NON TRANSFERABLE

DETACH RECEIPT FROM TICKET

DATE ISSUED

TIME ISSUED

AMOUNT PAID

05/17 10:21 AM \$ 2.75

CREDIT CARD NUMBER

meeting - Allen



UNIVERSITY OF ALBERTA

1075152

RECEIPT

GST # R108102831



DISPLAY THIS SIDE UP ON DASHBOARD

EXPIRATION DATE  
EXPIRATION TIME

2021 05:45 PM

AMOUNT PAID

\$ 2.75 240900000004:45 PM



UNIVERSITY OF ALBERTA 844361

NON TRANSFERABLE

DETACH RECEIPT FROM TICKET

DATE ISSUED TIME ISSUED AMOUNT PAID

2021 07 08:12 PM \$ 2.75

CREDIT CARD NUMBER



UNIVERSITY OF ALBERTA 844361

RECEIPT

GST # R108102831

APPLICANT COPY

DISPLAY THIS SIDE UP ON DASHBOARD

EXPIRATION DATE  
EXPIRATION TIME

2021 11:20 PM

AMOUNT PAID

\$ 4.00 240900000009:51 PM



UNIVERSITY OF ALBERTA 1060911

NON TRANSFERABLE

DETACH RECEIPT FROM TICKET

DATE ISSUED TIME ISSUED AMOUNT PAID

2021 07 08:12 PM \$ 4.00

CREDIT CARD NUMBER



UNIVERSITY OF ALBERTA 1060911

RECEIPT

GST # R108102831

DISPLAY THIS SIDE UP ON DASHBOARD

EXPIRATION DATE  
EXPIRATION TIME

2021 08:56 PM

AMOUNT PAID

\$ 2.00 152100000008:12 PM



UNIVERSITY OF ALBERTA 1076137

NON TRANSFERABLE

DETACH RECEIPT FROM TICKET

DATE ISSUED TIME ISSUED AMOUNT PAID

2021 07 08:12 PM \$ 2.00

CREDIT CARD NUMBER



UNIVERSITY OF ALBERTA 1076137

RECEIPT

GST # R108102831

APPLICANT COPY



**MILEAGE AND PARKING CLAIM FORM (WITHIN REGION)**

Program <i>EXEC</i>	Employee Name <i>Glenda Coleman-Miller</i>	Location <i>RAT</i>	Payroll #
------------------------	---	------------------------	-----------

s.17(1), 17(4)(g)(i)

**NOTE:** 1) It is the employee's responsibility to maintain adequate records to substantiate all mileage claims to Revenue Canada, Program Management, or Finance upon request. You must be able to provide documentation which shows the date, destination and km travelled on each of your trips.  
2) Driving to and from work is not considered business travel and must not be claimed.

Month <i>December</i>	Year <i>2007</i>
--------------------------	---------------------

Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	
1			9			17	<i>16</i>	<i>3.55</i>	25			
2			10			18			26			
3			11			19			27			
4			12	<i>16</i>	<i>2.00</i>	20			28			
5			13			21			29			
6			14	<i>6</i>	<i>6.00</i>	22			30			
7	<i>16</i>	<i>4.05</i>	15			23			31			
8			16			24						
										Total	<i>54</i>	<i>15.60</i>

Declaration: I hereby certify that the mileage and parking charges listed above were incurred on Capital Health business and that the amount has not been previously claimed by me or on my behalf.

APPLICANT COPY RECEIPT  
GST # R108102831

ALBERTA UNIVERSITY OF  
1086672

AMOUNT PAID \$ 2.00  
EXPIRATION DATE 12/12 05:44 PM  
DATE ISSUED 12/12/07 05:00 PM  
TIME ISSUED 05:00 PM  
AMOUNT PAID \$ 2.00

DETACH RECEIPT FROM TICKET

ALBERTA UNIVERSITY OF  
0934292  
GST # R108102831

AMOUNT PAID \$ 3.55  
EXPIRATION DATE 12/12 08:36 PM  
DATE ISSUED 12/12/07 07:17 PM  
TIME ISSUED 07:17 PM  
AMOUNT PAID \$ 3.55

DETACH RECEIPT FROM TICKET

ALBERTA UNIVERSITY OF  
1085731  
GST # R108102831

AMOUNT PAID \$ 4.05  
EXPIRATION DATE 07/12 09:45 PM  
DATE ISSUED 07/12/07 08:15 PM  
TIME ISSUED 08:15 PM  
AMOUNT PAID \$ 4.05

DETACH RECEIPT FROM TICKET

NON TRANSFERABLE  
ALBERTA UNIVERSITY OF  
1086672

AMOUNT PAID \$ 2.00  
EXPIRATION DATE 12/12 05:44 PM  
DATE ISSUED 12/12/07 05:00 PM  
TIME ISSUED 05:00 PM  
AMOUNT PAID \$ 2.00

DISPLAY THIS SIDE UP ON DASHBOARD

NON TRANSFERABLE  
ALBERTA UNIVERSITY OF  
0934292

AMOUNT PAID \$ 3.55  
EXPIRATION DATE 12/12 08:36 PM  
DATE ISSUED 12/12/07 07:17 PM  
TIME ISSUED 07:17 PM  
AMOUNT PAID \$ 3.55

DISPLAY THIS SIDE UP ON DASHBOARD

NON TRANSFERABLE  
ALBERTA UNIVERSITY OF  
1085731

AMOUNT PAID \$ 4.05  
EXPIRATION DATE 07/12 09:45 PM  
DATE ISSUED 07/12/07 08:15 PM  
TIME ISSUED 08:15 PM  
AMOUNT PAID \$ 4.05

DISPLAY THIS SIDE UP ON DASHBOARD

TICKET VOID IF RE-SOLD

INSTRUCTIONS ON BACK

3:57PM FRI  
Dec 14 07  
Impark

EXP: S.17(D)/17(4)(e.1)

Meter: 02023701  
Trans: 016211  
Time: 1:57P DEC 14  
Price: \$ 6.00  
Card:

Hourly Parking

Impark  
PH: 420-1976

PLACE THIS SIDE UP ON DASH

THIS SIDE UP ON DASH



APPLICANT COPY

MILEAGE AND PARKING CLAIM FORM (WITHIN REGION)

Program <i>EXEC</i>	Employee Name <i>Glenda Coleman-Miller</i>	Location <i>RAH</i>	Payroll #
------------------------	---	------------------------	-----------

s.17(1), 17(4)(g)(i)

- NOTE: 1) It is the employee's responsibility to maintain adequate records to substantiate all mileage claims to Revenue Canada, Program Management, or Finance upon request. You must be able to provide documentation which shows the date, destination and km travelled on each of your trips.
- 2) Driving to and from work is not considered business travel and must not be claimed.

Month <i>January</i>	Year <i>2008</i>
-------------------------	---------------------

Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	Date	KM	Parking
1			9			17			25		
2			10			18	<i>6</i>	<i>10.00</i>	26		
3			11	<i>6</i>	<i>2.00</i>	19			27		
4			12			20			28		
5			13			21			29		
6			14	<i>16</i>	<i>6.75</i>	22			30		
7			15	<i>6</i>		23			31		
8	<i>16</i>	<i>4.25</i>	16	<i>16</i>	<i>5.40</i>	24					

$$28.38 + 24.15 = 52.53$$

Total	<i>66</i>	<del><i>28.40</i></del>
-------	-----------	-------------------------

*24.15*

Declaration: I hereby certify that the mileage and parking charges listed above were incurred on Capital Health business and that the amount has not been previously claimed by me or on my behalf.



DISPLAY THIS SIDE UP ON DASHBOARD

EXPIRATION DATE

EXPIRATION TIME

11/201 07:39 AM

AMOUNT PAID

\$ 2.00 24090000006:55 AM



UNIVERSITY OF ALBERTA

739331

NON TRANSFERABLE

DETACH RECEIPT FROM TICKET

DATE ISSUED

TIME ISSUED

AMOUNT PAID

11/201 07:39 AM \$ 2.00

CREDIT CARD NUMBER



UNIVERSITY OF ALBERTA

739331

RECEIPT

GST # R108102831

APPLICANT COPY



Travel & Employee Expense Claim Form

(In Canadian Dollars) s.17(1), 17(4)(g)(i)

Name: Glenda Coleman-Miller	Employee Number:	Union Name:
Position: Senior Operating Officer	Department: Executive	
Business Phone: 735-5271	Period From: June 9/08 to June 9/08	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0002	711401001	62410000			\$156.76	<input checked="" type="checkbox"/>
		7110101001					<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
Total						\$156.76	<input checked="" type="checkbox"/>

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: *Glenda Coleman-Miller* Date: June 20, 2008

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: Joanna Pawlyshyn (Print name)	Title: V.P. & C.O.O.	Phone # 735-4101
(Signature) <i>[Signature]</i>	EXP 02 July 08	Date
Approved By:	Title:	Phone #
(Signature)	EXP 03 2008	Date

NOTE:

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
- GST amounts included in the expense claims will be calculated by Accounts Payable.
- Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
- For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
- For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
- See page 2 of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP





Royal Mayfair Golf Club

----- Chit Details -----

**Best Copy Possible**

Member: G  
 Ser: N  
 Ad:  
 Lat: Covers: 4  
 s.17(1), 17(4)(g)(i)

Date: Jun 10 08 Time: 7:44pm

Peaches & Butterleaf	9.00
Peaches & Butterleaf	9.00
Peaches & Butterleaf	9.00
Peaches & Butterleaf	9.00
3 Smoked Salmon & Brie	36.00
8oz Thompson Burger	9.75
2 Moore's Crk Chard G1	17.50
2 Fab Pinot Grigio Gls	14.50
2 Mirassou P Noir Gls	16.50

Sub-Total: 130.25  
 GST # 119322980 6.51

Chit Total: \$136.76

Gratuity: 2.00

Total: 156.76

ATTENDEES:

DALE SHARD  
 LOIS STEFANIUK  
 JOANNA PAWLYSHYN  
 GLENDA COLEMAN - MILLER

Do you Hula?  
 Hawaiian Luau July 11th

----- End of Chit -----

s.17(1), 17(4)(e.1)

MAYFAIR GOLF & COUNTRY  
 9450 GROAT RD T6G2T5  
 EDMONTON AB  
 22612937  
 PRE AUTH PURCHASE  
 06-05-2008 19:51:00  
 Acct # C  
 Exp. Card Type VI  
 Name GLENDAN-MILLER/GLENDA  
 -A0000000031010 RBC VISA AVION

Trace # 580007  
 FS2261293702  
 Inv. # 143  
 Auth 017916 RRN 001381007

P.Auth Purchase \$136.76

Tip 20.00  
 Total 156.76

Customer copy



Employee Expense Claim Form

Canadian Dollars) s.17(1), 17(4)(g)(i)

Name: Glenda Coleman-Miller, Position: Senior Operating Officer, Business Phone: 735-5271, Employee Number: , Union Name: , Department: RAH - Exec, Term: May 2008 to August 2008

Expenses Paid (please attach receipts from another organization. Complete details of the form)

Table with columns: Bal Unit e.g. 201, Location e.g. 9000, Functional Code e.g. 7113505, Amount, Non-Canadian Currency, Rate, Canadian \$ (including GST), Check if GST included

Table with columns: Amount, Non-Canadian Currency, Rate, Canadian \$ (including GST), Check if GST included. Total: \$354.75

Capital Health RECEIVED SEP 09 2008 ACCOUNTS PAYABLE

The information on this form is collected and will be used to process your claim.

of the Regional Health Authorities (Ministerial) Regulation and

I hereby certify that the expenses listed herein were incurred on Capital Health business and have not been previously claimed by me or on my behalf from any other organization.

Employee Signature: [Signature], Date: Aug 29/08

I hereby certify that I have reviewed the expenses and the mileage rate at which mileage is being claimed.

Approved By: Joanna Pawlyshyn (Print name), (Signature), Approved By: (Print name), (Signature)

V.P. & C.O.O. Phone # 735-4101, Date: 04 Sept 08

NOTE:

- Expense claim must be properly supported by original receipts or a copy as certified by the approver. The approver must initial and approve the claim form. Fully completed Travel & Employee Expense Claim Form will be processed the following week. For all employees on the payroll system... See page 2 of this form for expense details. Approved claim form with receipts should be submitted to Accounts Payable (Capital Health Centre, North Tower - 10th Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4) in advance authorized by a COO or VP.

be supported by original receipts or a copy as certified by the approver. The approver must initial and approve the claim form. Fully completed Travel & Employee Expense Claim Form will be processed the following week. For all employees on the payroll system... See page 2 of this form for expense details. Approved claim form with receipts should be submitted to Accounts Payable (Capital Health Centre, North Tower - 10th Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4) in advance authorized by a COO or VP.



APPLICANT COPY



MILEAGE AND PARKING CLAIM FORM (WITHIN REGION)

Program <b>EXEC</b>	Employee Name <b>Glenda Coleman-Miller</b>	Location <b>RAH</b>	Payroll #
------------------------	---	------------------------	-----------

NOTE: 1) It is the employee's responsibility to maintain adequate records to substantiate all mileage claims to Revenue Canada, Program Management, or Finance upon request. You must be able to provide documentation which shows the date, destination and km travelled on each of your trips. s.17(1), 17(4)(g)(i)

2) Driving to and from work is not considered business travel and must not be claimed.

Month <b>May</b>	Year <b>2008</b>
---------------------	---------------------

Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	Date	KM	Parking
1			9			17			25		
2			10			18			26		
3			11			19			27		
4			12	16	5.80	20			28		
5			13	6	2.00	21	16	5.00	29	16	7.25
6			14	6	5.00	22	16	7.25	30		
7	16	5.00	15	16	3.05	23			31		
8	16	8.70	16			24					

Total	124	49.05
-------	-----	-------

Declaration: I hereby certify that the mileage and parking charges listed above were incurred on Capital Health business and that the amount has not been previously claimed by me or on my behalf.

APPLICANT COPY

INSTRUCTIONS ON BACK  
Please remember the  
Parkade will close @ 5pm  
PLACE

PLACE THIS SIDE UP ON DASH  
IMPERIAL PARKING  
COUNTY PERMIT  
Meter: 265  
Transit: 025024  
Line: 11557  
Imperial  
Expires: 13  
8:22AM TUE  
MAY 13 08

TICKET VOID IF RE-SOLD

12831

RECEIPT GS

ALBERTA UNIVERSITY OF



CREDIT CARD NUMBER

07/05/08 09:52 AM \$ 5

DATE ISSUED TIME ISSUED AMOUNT PAID

DETACH RECEIPT FROM

12831

RECEIPT GS

ALBERTA UNIVERSITY OF



CREDIT CARD NUMBER

s.17(1), 17(4)(e.1)

08/05/08 09:56 AM \$ 8

DATE ISSUED TIME ISSUED AMOUNT PAID

DETACH RECEIPT FROM

12831

RECEIPT GS

ALBERTA UNIVERSITY OF



CREDIT CARD NUMBER

s.17(1), 17(4)(e.1)

12/05/08 05:54 PM \$ 5

DATE ISSUED TIME ISSUED AMOUNT PAID

DETACH RECEIPT FROM

NON TRANSFERABLE

ALBERTA UNIVERSITY OF



AMOUNT PAID

\$ 5.00 24090000 09:52 AM

07/05 11:36 AM

EXPIRATION DATE

DISPLAY THIS SIDE UP ON DASHBOARD

NON TRANSFERABLE

ALBERTA UNIVERSITY OF



AMOUNT PAID

\$ 8.70 24090000 09:56 AM

08/05 09:56 AM

EXPIRATION DATE

DISPLAY THIS SIDE UP ON DASHBOARD

NON TRANSFERABLE

ALBERTA UNIVERSITY OF



AMOUNT PAID

\$ 5.80 24090000 05:54 PM

12/05 05:54 PM

EXPIRATION DATE

DISPLAY THIS SIDE UP ON DASHBOARD

UNIVERSITY OF ALBERTA 0965331

UNIVERSITY OF ALBERTA 0965331

21/05/08 11:47 AM \$ 5.00  
DATE ISSUED TIME ISSUED AMOUNT PAID  
CREDIT CARD NUMBER

21/05 01:31 PM  
EXPIRATION DATE  
EXPIRATION TIME  
AMOUNT PAID \$ 5.00 24090000 11:47 AM

UNIVERSITY OF ALBERTA 0965607  
s.17(1), 17(4)(e.1)  
CREDIT CARD NUMBER

UNIVERSITY OF ALBERTA 0965607  
22/05/08 02:15 PM \$ 7.25  
DATE ISSUED TIME ISSUED AMOUNT PAID

22/05/08 02:15 PM \$ 7.25  
DATE ISSUED TIME ISSUED AMOUNT PAID  
CREDIT CARD NUMBER

22/05 04:43 PM  
EXPIRATION DATE  
EXPIRATION TIME  
AMOUNT PAID \$ 7.25 24090000 02:15 PM

UNIVERSITY OF ALBERTA 0881078  
CREDIT CARD NUMBER

UNIVERSITY OF ALBERTA 0881078

15/05/08 04:28 PM \$ 3.05  
DATE ISSUED TIME ISSUED AMOUNT PAID  
CREDIT CARD NUMBER

15/05 05:31 PM  
EXPIRATION DATE  
EXPIRATION TIME  
AMOUNT PAID \$ 3.05 24090000 04:28 PM

UNIVERSITY OF ALBERTA 0967171  
s.17(1), 17(4)(e.1)  
CREDIT CARD NUMBER

UNIVERSITY OF ALBERTA 0967171  
29/05/08 03:54 PM \$ 7.25  
DATE ISSUED TIME ISSUED AMOUNT PAID

29/05/08 03:54 PM \$ 7.25  
DATE ISSUED TIME ISSUED AMOUNT PAID  
CREDIT CARD NUMBER

29/05 06:24 PM  
EXPIRATION DATE  
EXPIRATION TIME  
AMOUNT PAID \$ 7.25 24090000 03:54 PM

**DISPLAY FACE UP ON DASH**

**Impark Lot 002-256**

EDMONTON, AB. 780-420-1976  
GST #88731 5638 RT0001  
Machine Serial #:000005071052

EXPIRY DATE AND TIME

**EXP 01:55pm**

**MAY 14, 2008**

TICKET# LOT#

**00087892 00020256**

CC \$0005.00 Visa MACH# 01  
FOLLOW INSTRUCTIONS ON SIGNS POSTED

**1 Hour \$5.00**

Pay from your cell phone  
423-1922 Location 9804  
goto [www.ImparkWireless.com](http://www.ImparkWireless.com)

**DISPLAY FACE UP ON DASH**

s.17(1), 17(4)(e.1)

APPLICANT COPY



MILEAGE AND PARKING CLAIM FORM (WITHIN REGION)

Program <i>EXEC</i>	Employee Name <i>Glenda Coleman-Miller</i>	Location <i>RAH</i>	Payroll #
------------------------	---	------------------------	-----------

s.17(1), 17(4)(g)(i)

NOTE: 1) It is the employee's responsibility to maintain adequate records to substantiate all mileage claims to Revenue Canada, Program Management, or Finance upon request. You must be able to provide documentation which shows the date, destination and km travelled on each of your trips.  
2) Driving to and from work is not considered business travel and must not be claimed.

Month <i>June</i>	Year <i>2008</i>
----------------------	---------------------

Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	
1			9			17			25	<i>16</i>	<i>10.15</i>	
2	<i>16</i>	<i>4.35</i>	10			18			26			
3			11			19	<i>16</i>	<i>5.00</i>	27			
4			12	<i>16</i>	<i>7.25</i>	20			28			
5			13			21			29			
6			14			22			30			
7			15			23	<i>16</i>	<i>4.35</i>	31			
8			16			24	<i>16</i>	<i>5.00</i>				
										Total	<i>86</i>	<i>36.10</i>

Declaration: I hereby certify that the mileage and parking charges listed above were incurred on Capital Health business and that the amount has not been previously claimed by me or on my behalf.



UNIVERSITY OF ALBERTA  
 951974

AMOUNT PAID \$ 4.35 2409000007:50 AM

EXPIRATION DATE 02/06 09:20 AM  
 EXPIRATION TIME

SPRAY THIS SIDE UP ON DASHBOARD

UNIVERSITY OF ALBERTA  
 951974

CREDIT CARD NUMBER s.17(1), 17(4)(e.1)

DATE ISSUED 02/06/08 07:50 AM  
 TIME ISSUED  
 AMOUNT PAID \$ 4.35

DETACH RECEIPT FROM TICKET

NON TRANSFERABLE

UNIVERSITY OF ALBERTA  
 814764

AMOUNT PAID \$ 7.25 2409000006:54 AM

EXPIRATION DATE 12/06 09:24 AM  
 EXPIRATION TIME

DISPLAY THIS SIDE UP ON DASHBOARD

RECEIPT

UNIVERSITY OF ALBERTA  
 814764

CREDIT CARD NUMBER s.17(1), 17(4)(e.1)

DATE ISSUED 12/06/08 06:54 AM  
 TIME ISSUED  
 AMOUNT PAID \$ 7.25

DETACH RECEIPT FROM TICKET

GST# R108102831

NON TRANSFERABLE

UNIVERSITY OF ALBERTA  
 821335

AMOUNT PAID \$ 4.35 24090000010:24 AM

EXPIRATION DATE 12/06 11:54 AM  
 EXPIRATION TIME

DISPLAY THIS SIDE UP ON DASHBOARD

RECEIPT

UNIVERSITY OF ALBERTA  
 821335

CREDIT CARD NUMBER s.17(1), 17(4)(e.1)

DATE ISSUED 12/06/08 10:24 AM  
 TIME ISSUED  
 AMOUNT PAID \$ 4.35

DETACH RECEIPT FROM TICKET

GST# R108102831

NON TRANSFERABLE

UNIVERSITY OF ALBERTA  
 821756

AMOUNT PAID \$ 10.15 2409000006:51 AM

EXPIRATION DATE 25/06 10:21 AM  
 EXPIRATION TIME

DISPLAY THIS SIDE UP ON DASHBOARD

RECEIPT

UNIVERSITY OF ALBERTA  
 821756

CREDIT CARD NUMBER s.17(1), 17(4)(e.1)

DATE ISSUED 25/06/08 06:51 AM  
 TIME ISSUED  
 AMOUNT PAID \$ 10.15

DETACH RECEIPT FROM TICKET

GST# R108102831

RECEIPT  
UNIVERSITY OF ALBERTA  
816151  
GST # R108102831



DATE ISSUED 19/06/08 09:35 AM  
TIME ISSUED 09:35 AM  
AMOUNT PAID \$ 5.00  
CREDIT CARD NUMBER

DETACH RECEIPT FROM TICKET

NON TRANSFERABLE  
UNIVERSITY OF ALBERTA  
816151  
EXPIRATION DATE 19/06 11:19 AM  
AMOUNT PAID \$ 5.00 2409000009:35 AM  
EXPIRATION TIME 19/06 11:19 AM  
DISPLAY THIS SIDE UP ON DASHBOARD



DISPLAY FACE UP ON DASH

**EXP 04:59pm**  
**JUN 24, 2008**

EXPIRY DATE AND TIME

Impark Lot 002-256  
EDMONTON, AB, 780-420-1976  
GST #88731 5638 RT0001  
Machine Serial #:000005071052

TICKET# 00092672 LOT# 00020256  
MACH# 001

CC \$0005100  
TIC# 00092672  
JUN24, 2008  
03:59pm  
Purchase Time

FOLLOW INSTRUCTIONS ON SIGNS POSTED

s.17(1), 17(4)(e.1)  
1 Hour \$5.00

Pay from your cell phone.  
423-1922 Location 9804.  
goto www.ImparkWireless.com

DISPLAY FACE UP ON DASH RECEIPT

s.17(1), 17(4)(e.1)

APPLICANT COPY



MILEAGE AND PARKING CLAIM FORM (WITHIN REGION)

Program <i>EXEC</i>	Employee Name <i>Glenda Coleman-Miller</i>	Location <i>RAH</i>	Payroll #
------------------------	---	------------------------	-----------

NOTE: 1) It is the employee's responsibility to maintain adequate records to substantiate all mileage claims to Revenue Canada, Program Management, or Finance upon request. You must be able to provide documentation which shows the date, destination and km travelled on each of your trips. s:17(1), 17(4)(g)(i)

2) Driving to and from work is not considered business travel and must not be claimed.

Month <i>July 2008</i>	Year <i>2008</i>
---------------------------	---------------------

Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	
1			9			17			25			
2			10			18			26			
3			11			19			27			
4			12			20			28	<i>6</i>	<i>6.00</i>	
5			13			21			29			
6			14	<i>6</i>	<i>5.00</i>	22	<i>6</i>	<i>5.00</i>	30			
7			15			23			31			
8			16			24						
										Total	<i>18</i>	<i>16.00</i>

Declaration: I hereby certify that the mileage and parking charges listed above were incurred on Capital Health business and that the amount has not been previously claimed by me or on my behalf.

DISPLAY FACE UP ON DASH RECEIPT

Impark Lot 002-256

EDMONTON, AB 780-420-1976  
GST #88731 5638 RT0001  
Machine Serial #:00000507052

EXPIRY DATE AND TIME

EXP 03:57pm  
JUL 14, 2008

TICKET# LOT#  
00094870 00020256

OT \$0005.00 Visa MACH# 001  
FOLLOW INSTRUCTIONS ON SIGNS POSTED  
S.17(1), 17(4)(e.1)

1 Hour \$5.00

Pay from your cell phone.  
423-1922 Location 9804.  
goto www.imparkwireless.com

DISPLAY FACE UP ON DASH RECEIPT

s.17(1), 17(4)(e.1)

APPLICANT COPY

DISPLAY FACE UP ON DASH RECEIPT

Impark Lot 002-256

EDMONTON, AB 780-420-1976  
GST #88731 5638 RT0001  
Machine Serial #:00000507052

EXPIRY DATE AND TIME

EXP 11:22am  
JUL 22, 2008

TICKET# LOT#  
00095912 00020256

CC \$0005.00 Visa MACH# 001  
FOLLOW INSTRUCTIONS ON SIGNS POSTED  
S.17(1), 17(4)(e.1)

1 Hour \$5.00

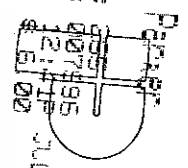
Pay from your cell phone.  
423-1922 Location 9804.  
goto www.imparkwireless.com

DISPLAY FACE UP ON DASH RECEIPT

s.17(1), 17(4)(e.1)

IMPERIAL PARKING

TICKET



INSTRUCTIONS ON BACK  
Please remember the  
Perfide will close @ 5pm P

JUL 28 08

APPLICANT COPY



Capital Health

MILEAGE AND PARKING CLAIM FORM (WITHIN REGION)

Program <b>EXEC</b>	Employee Name <b>Glenda Coleman-Miller</b>	Location <b>RAH</b>	Payroll #
------------------------	---	------------------------	-----------

s.17(1), 17(4)(g)(i)

NOTE: 1) It is the employee's responsibility to maintain adequate records to substantiate all mileage claims to Revenue Canada, Program Management, or Finance upon request. You must be able to provide documentation which shows the date, destination and km travelled on each of your trips.  
2) Driving to and from work is not considered business travel and must not be claimed.

Month <b>August</b>	Year <b>2008</b>
------------------------	---------------------

Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	Date	KM	Parking
1			9			17			25	22	9.35(6)
2			10			18			26	16	4.35
3			11			19			27	16	4.35
4			12			20	16	8.70	28		
5	16		13	16	11.60	21	21	5.00	29		
6	16	4.35	14	16	4.35	22			30		
7	16	13.05	15			23			31		
8	6	14.35(2)	16			24			Total <b>117</b> <b>79.45</b>		

Declaration: I hereby certify that the mileage and parking charges listed above were incurred on Capital Health business and that the amount has not been previously claimed by me or on my behalf.

PRECISE PARKLINK  
 NON TRANSFERABLE  
 CHARGES ARE FOR THE USE OF THE PARKING SPACE ONLY  
 WE WILL NOT BE RESPONSIBLE FOR LOSS OR DAMAGE TO  
 CAR OR CONTENTS, HOWEVER CAUSED, INCLUDING BUT NOT  
 LIMITED TO FIRE, THEFT OR COLLISION

APPLICANT COPY

s.17(1), 17(4)(e.1)

AMOUNT PAID \$ 5.80 24090000 07:46 PM  
 EXPIRATION DATE 21/08/08 09:46 PM  
 EXPIRATION TIME  
 DATE ISSUED 21/08/08 07:46 PM  
 TIME ISSUED  
 AMOUNT PAID \$ 5.80  
 CREDIT CARD NUMBER  
 DETACH RECEIPT FROM TICKET

PRECISE PARKLINK  
 NON TRANSFERABLE  
 CHARGES ARE FOR THE USE OF THE PARKING SPACE ONLY  
 WE WILL NOT BE RESPONSIBLE FOR LOSS OR DAMAGE TO  
 CAR OR CONTENTS, HOWEVER CAUSED, INCLUDING BUT NOT  
 LIMITED TO FIRE, THEFT OR COLLISION

s.17(1), 17(4)(e.1)

AMOUNT PAID \$ 8.70 24090000 11:46 PM  
 EXPIRATION DATE 20/08/08 02:46 PM  
 EXPIRATION TIME  
 DATE ISSUED 20/08/08 11:46 PM  
 TIME ISSUED  
 AMOUNT PAID \$ 8.70  
 CREDIT CARD NUMBER  
 DETACH RECEIPT FROM TICKET

GST # R108102831



s.17(1), 17(4)(e.1)

AMOUNT PAID \$ 11.60 24090000 11:53 PM  
 EXPIRATION DATE 13/08/08 03:53 PM  
 EXPIRATION TIME  
 DATE ISSUED 13/08/08 11:53 PM  
 TIME ISSUED  
 AMOUNT PAID \$ 11.60  
 CREDIT CARD NUMBER  
 DETACH RECEIPT FROM TICKET

**DISPLAY FACE UP ON DASH RECIPT**

Impark Lot 002-256  
 EDMONTON, AB 780-420-1976  
 GST #88731 5638 RT0001  
 Machine Serial #:000005070652

EXPIRY DATE AND TIME s.17(1), 17(4)(e.1)  
 EXP 03:57pm 1:01# 00020256  
 AUG 08, 2008 1:01# 00020256  
 TICKET# 00097869 LOT# 00020256  
 CC \$0010.00 Visa MACH# 001  
 FOLLOW INSTRUCTIONS ON SIGNS POSTED 1:57pm  
 Purchase Time

2 Hours \$10.00  
 Pay from your cell phone.  
 423-1922 Location 9804.  
 goto www.ImparkWireless.com

**DISPLAY FACE UP ON DASH RECIPT**

s.17(1), 17(4)(e.1)

GST # R108102831

UNIVERSITY OF ALBERTA  
RECEIPT  
APPLICANT COPY

CREDIT CARD NUMBER  
s.17(1), 17(4)(e.1)

05/08/08 07:55 AM \$ 4.35  
DATE ISSUED TIME ISSUED AMOUNT PAID

DETACH RECEIPT FROM TICKET

NON TRANSFERABLE

UNIVERSITY OF ALBERTA

AMOUNT PAID  
\$ 4.35 2409000007:55 AM

05/08 09:25 AM  
EXPIRATION DATE EXPIRATION TIME

DISPLAY THIS SIDE UP ON DASHBOARD

GST # R108102831

UNIVERSITY OF ALBERTA  
RECEIPT

CREDIT CARD NUMBER  
s.17(1), 17(4)(e.1)

07/08/08 07:54 AM \$ 13.05  
DATE ISSUED TIME ISSUED AMOUNT PAID

DETACH RECEIPT FROM TICKET

NON TRANSFERABLE

UNIVERSITY OF ALBERTA

AMOUNT PAID  
\$ 13.05 2409000007:54 AM

07/08 12:24 PM  
EXPIRATION DATE EXPIRATION TIME

DISPLAY THIS SIDE UP ON DASHBOARD

GST # R108102831

UNIVERSITY OF ALBERTA  
RECEIPT

CREDIT CARD NUMBER  
s.17(1), 17(4)(e.1)

14/08/08 07:49 AM \$ 4.35  
DATE ISSUED TIME ISSUED AMOUNT PAID

DETACH RECEIPT FROM TICKET

NON TRANSFERABLE

UNIVERSITY OF ALBERTA

AMOUNT PAID  
\$ 4.35 2409000007:49 AM

14/08 09:19 AM  
EXPIRATION DATE EXPIRATION TIME

DISPLAY THIS SIDE UP ON DASHBOARD

GST # R108102831

UNIVERSITY OF ALBERTA  
RECEIPT

CREDIT CARD NUMBER  
s.17(1), 17(4)(e.1)

06/08/08 07:51 AM \$ 4.35  
DATE ISSUED TIME ISSUED AMOUNT PAID

DETACH RECEIPT FROM TICKET

NON TRANSFERABLE

UNIVERSITY OF ALBERTA

AMOUNT PAID  
\$ 4.35 2409000007:51 AM

06/08 09:21 AM  
EXPIRATION DATE EXPIRATION TIME

DISPLAY THIS SIDE UP ON DASHBOARD

DISPLAY FACE UP ON DASHBOARD

IMPARK Lot 002-256  
EDMONTON AB 780-420-1976  
GST #88731 5638 RT00001  
Machine Serial #:00000507162

EXPIRY DATE AND TIME  
EXP 01:57pm  
AUG 25 2008

EXP 01:57pm  
AUG 25, 2008

TICKET# 00099510  
LOT# 00020256

LOT# 00099510  
MACH# 001  
TIC# 00099510  
AUG25 2008  
MACH# 001  
Purchase Time 12:57pm

1 Hour \$5.00

Buy from your cell phone.  
423-1922 Location 9804.  
Info www.ImparkWireless.com

APPLICABLE COPY

DISPLAY FACE UP ON DASHBOARD



NON TRANSFERABLE  
WE WILL NOT BE RESPONSIBLE FOR LOSS OR DAMAGE TO CAR OR CONTENTS, HOWEVER CAUSED, INCLUDING BUT NOT LIMITED TO FIRE, THEFT OR COLLISION.  
CHARGES ARE FOR THE USE OF THE PARKING SPACE ONLY.

EXPIRATION DATE  
25/08 09:21 PM  
AMOUNT PAID  
\$ 4.35 2409000007:51 AM  
CREDIT CARD NUMBER  
s.17(1), 17(4)(e.1)

DATE ISSUED  
25/08/08 07:51 PM  
TIME ISSUED  
AMOUNT PAID  
\$ 4.35

DETACH RECEIPT FROM TICKET

RECEIPT

29508474



NON TRANSFERABLE  
WE WILL NOT BE RESPONSIBLE FOR LOSS OR DAMAGE TO CAR OR CONTENTS, HOWEVER CAUSED, INCLUDING BUT NOT LIMITED TO FIRE, THEFT OR COLLISION.  
CHARGES ARE FOR THE USE OF THE PARKING SPACE ONLY.

EXPIRATION DATE  
26/08 09:30 PM  
AMOUNT PAID  
\$ 4.35 2409000008:00 AM  
CREDIT CARD NUMBER  
s.17(1), 17(4)(e.1)

DATE ISSUED  
26/08/08 08:00 PM  
TIME ISSUED  
AMOUNT PAID  
\$ 4.35

DETACH RECEIPT FROM TICKET

RECEIPT

29508714



NON TRANSFERABLE  
UNIVERSITY OF ALBERTA  
1296272

EXPIRATION DATE  
27/08 05:59 PM  
AMOUNT PAID  
\$ 4.35 2409000002:29 PM  
CREDIT CARD NUMBER  
s.17(1), 17(4)(e.1)

DATE ISSUED  
27/08/08 02:29 PM  
TIME ISSUED  
AMOUNT PAID  
\$ 4.35

DETACH RECEIPT FROM TICKET

RECEIPT

GST # R108102831

UNIVERSITY OF ALBERTA  
1296272



1. Required fields are Invoice date, Invoice number, Vendor name.

2. Address is required if there is no invoice.

3. In all cases if a P.O. was used it must be noted.

4. Complete entire section.

5. CMS contract number is provided by CCO.

6. The exemption numbers are assigned by Accounting Services

7. For invoices with a purchase order, only invoice total is required.

8. All fields are required if there is no purchase order.

9. All codes must be Oracle codes - do not use Vax or Tandem codes.

10. Check with Business Support for available codes.

11. This section is required for all payments.

12. Approver should not be requisitioner unless no other person is available.

13. Approver confirms that this payment has not already been made.

**I PAYEE INFORMATION** (Check one only)  Vendor  Patient

Invoice Date **October 15, 2008**

Invoice Number

PO #

Vendor Name **Glenda Coleman-Miller**

s.17(1), 17(4)(g)

Vendor Number

Address

City

Province/State

Postal Code

Country

**II PAYMENT DETAILS**

Reason for payment: **Reimbursement of expenses - dinner with keynote speakers for Speaking of Women's Health Conference (Oct. 3/08)**

Is this a P.O. or contract payment?  Yes  No

If this purchase requires a contract and you do not have a CMS contract number, please contact Corporate Contracting Office (CCO)

CMS (Contract Management System) Contract Number

If **not** a contract or PO purchase, does it comply with items under CAD 4.4.1 Section A, 6 (f) Page 2

Yes describe (**staff expenses**)  No, exemption # -

Goods / services have been received, price agrees to contract or P.O. as applicable and calculation is correct (Items were received as ordered, are in good condition, will be used by department and pricing/calculations checked)

Yes,  No Explain Below

Explanation:

Are original attachments to be mailed with cheque? (Note 2)  Yes  No

**III EXPENSE CODES (IN ORACLE FINANCIAL SYSTEM FORMAT)**  
(Departments must provide Complete Coding)

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Expense Sub-Total	GST if applicable	Total Payment
<b>201</b>	<b>0002</b>	<b>71558000206</b>	<del>1202400</del> <i>6950 0000</i>	<b>\$424.85</b>		<b>\$424.85</b>

Currency (select one)

Canadian  U.S.  Other

<b>TOTAL</b>	<b>\$424.85</b>		<b>\$424.85</b>
--------------	-----------------	--	-----------------

**IV AUTHORIZATION**

I confirm that the above items have not been previously paid, the expenses relate only to Capital Health business and information provided on this form is accurate and complete.

Requisitioned by (Print name) <b>Desiree Olafson</b>	(Signature)	Phone # <b>735-5779</b>
Title: <b>Executive Secretary</b>		Date <b>Oct. 15, 2008</b>
Approved by (Print name) <b>Joanna Pawlyshyn</b>	(Signature)	Phone # <b>735-4101</b>
Title: <b>VP &amp; COO</b>	Signing Authority Level # <b>4</b>	Date
Approved by (Print name)	(Signature)	Phone #
Title:	Signing Authority Level #	Date

**AUTHORIZATIONS SHOULD BE IN ACCORDANCE WITH SIGNING AUTHORITY POLICY NUMBER FINANCE 4.1 – SEE PAGE 2 FOR DETAILS**

Notes:

- 1) All employee claims must be submitted on the Travel & Employee Expense Claim form
- 2) All cheques and attachments will be mailed out by Accounting Services. Cheques will **NOT** be pulled and returned to departments for mailing.
- 3) Fully completed payment requisitions received in Accounting Services by **MONDAY, 4:00 p.m.** will be processed that week.
- 4) **Incomplete/improperly authorized payment requisitions will be returned without processing**

November 2006, CH -0148

153

40

# APPLICANT COPY

**Guidance for Approval of Invoice Payments – Excerpt from Delegations of Signing Authority**  
**Note: Refer to CAD if payment is for Capital Equipment, Information Systems, Physicians Agencies or Non Hospital Surgical Facilities**

Contracted

Decision/transaction	Authority	Limits (Cdn \$)
<b>Authority Levels</b> Level 1 Board Level 2 President Level 3 Executive Vice President, Finance and Administration and CFO Level 4 COO, VP, CIO, CPO, LO, MOH (or equivalent approved by Level 3) Level 5 SOO, Regional Director, Senior Director or equivalent Level 6 Director or equivalent Level 7 Manager or equivalent Level 8 Coordinator, Supervisor or equivalent Level 9 Business Support Directors/Assistant Directors		
<b>Approval for invoice payments</b>		
6(c) Payments for consulting and other service agreements <u>under contract</u>	<ul style="list-style-type: none"> <li>• Level 1</li> <li>• Level 2</li> <li>• Level 3</li> <li>• Level 4</li> <li>• Level 5</li> <li>• Level 6</li> </ul>	None \$1,000,000 \$500,000 \$250,000 \$100,000 \$50,000
6(f) Items not requiring purchase order or contract	<ul style="list-style-type: none"> <li>• Level 1</li> <li>• Level 2</li> <li>• Level 3</li> <li>• Level 4</li> <li>• Level 5</li> <li>• Level 6</li> </ul>	None 100,000 20,000 10,000 5,000 1,000
<ul style="list-style-type: none"> <li>• Cell Phone/Pager monthly charges</li> <li>• Catering/Events – including short term space rental and related items e.g. cleaning, set up, and sound/video equipment rental</li> <li>• Office water, coffee and related supplies</li> <li>• Hotel accommodation and car rentals</li> <li>• Petty cash reimbursements</li> <li>• Subscriptions, journals, periodicals</li> <li>• Course registration fees for Educational training, Seminars, web access registration, teleconferencing charges</li> <li>• Employee &amp; Volunteer mileage &amp; expenses</li> <li>• Permits &amp; license fees, title searches, credit checks</li> <li>• Memberships, library books, preprinted educational materials</li> <li>• Freight charges, courier fees</li> <li>• Postage meter refills</li> <li>• Print, radio, television or internet advertising</li> <li>• Physician mileage &amp; expenses</li> <li>• Utilities—see section for signing authority levels</li> <li>• Honorariums</li> <li>• Sponsorships</li> <li>• Decorations and flowers</li> <li>• Authorized staff appreciation gifts under \$200 (excluding-cash/near cash items)</li> <li>• Temporary staffing through staffing agencies</li> <li>• Emergency items and other reimbursements for personal property"</li> <li>• Accounts Receivable billing refunds, as per approval levels described in Section H – Financing and Investing/Patient Trust payments</li> <li>• Offsite file storage, locksmiths, waste removal and shredding</li> <li>• Emergency vehicle maintenance/towing for Capital Health vehicles</li> <li>• Language Interpretation services</li> <li>• Internet, super-net and similar services for CH employees to access CH network</li> <li>• Clinical Interpretation fees e.g. ECG, EEG, etc where approved regional rates are being utilized</li> <li>• Emergency equipment maintenance under \$1,000</li> </ul>		
<b>No other payments allowed</b>		<b>allowed</b>



# APPLICANT COPY

## Travel & Employee Expense Claim Form

(In Canadian Dollars)

s.17(1), 17(4)(g)(i)

Name: Glenda Coleman-Miller	Employee Number:	Union Name:
Position: Senior Operating Officer	Department: Executive	
Business Phone: 735-5271	Period From: October 3 to October 3, 2008	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0002	71558000206	1202400			\$424.85	<input checked="" type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
Total						\$424.85	<input checked="" type="checkbox"/>

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature:

Date: October 14<sup>th</sup>, 2008

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: Joanna Pawlyshyn <i>(Print name)</i>	Title: V.P. & C.O.O.	Phone # 735-4101
<i>(Signature)</i>		Date
Approved By:	Title:	Phone #
<i>(Signature)</i>		Date

### NOTE:

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
- GST amounts included in the expense claims will be calculated by Accounts Payable.
- Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
- For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
- For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
- See page 2 of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

**EXPENSE CLAIM FORM**

**Recommended Coding**

- Local Travel – Staff - 62410000
- Staff Local Travel – Taxi – 62410001
- Staff Travel – UNA – 62410002
- Staff Provincial Travel – 62412000 (all expenses)
- Staff Out of Province Travel – 62414000 (all expenses)
- Catering – 69600000
- Meals - 62410000
- Mileage – 62410000
- Course Registration & Materials – 61030000

Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
Oct. 3/08	Dinner with SOWH Presenters		\$424.85				
<b>Total km</b>							
<b>Rate as outlined in Section 2 – Travel below @</b>							
<b>Totals</b>			\$424.85				

**EXPENSE LIMITS**

**1. Meal Allowances**

When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:

- Breakfast     \$8.50 (if the departure time is earlier or the return time is later than 7:30 a.m.)
- Lunch         \$10.75 (if the departure time is earlier or the return time is later than 1:00 p.m.)
- Dinner        \$19.20 (if the departure time is earlier or the return time is later than 6:30 p.m.)

For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.

Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.

**2. Travel**

- Use of personal automobile – From March 1, 2006, reimbursement at the general rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
- Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
- Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
  1. Monthly travel in excess of 340 kilometers; or
  2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
  3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
- If union contract rate differs from \$0.43 then contract rate must be used.
- Includes all forms of transportation costs, including taxis and buses for local travel.
- Driving to and from work is not considered business travel and cannot be claimed.

**3. Advance**

Travel advance may be requested provided travel expenses are likely to exceed \$500.

APPLICANT COPY

CHARACTERS REST  
10257 - 105 Street  
EDMONTON, AB.  
T5J 1E3  
(780) 421-4100  
GST# 89206-4429

CHARACTERS REST  
10257 - 105 STREET  
EDMONTON, AB.  
T5J 1E3

421-4100

GST# 89206-4429

Date: Oct03'08 09:10PM

Card Type: VISA

Acct #: 088947

Exp Date: 3119

Acct. Code: 11/1

146 LEFEBVRE

G COLEMAN MILLER

Keynote  
Koy s.17(1), 17(4)(e.1)

*Don't forget to tip  
at least 15%  
at the bar  
and 10% at the  
table  
if you are  
not a regular  
customer*

*374.85  
50.00  
424.85*

146 LEFEBVRE

Tbl 11/1 Chk 3119 Gst 4  
Oct03'08 06:13PM

2 CRAB CAKE @ 13.00	26.00
2 @ 16.00	
SEAFOOD PLATTER	32.00
3 @ 11.00	
BABY OCTOPUS	33.00
1 MIXED GREENS	8.00
3 SEA BASS @ 42.00	126.00
1 LAMB TRIO	38.00
2 @ 47.00	
4 MONDAVI CHARD	94.00

Subtotal 357.00  
GST 17.85

09:09 Amount Du **374.85**

WELCOME TO CHARACTERS!  
& HAVE A GREAT DAY!!

Signature \_\_\_\_\_  
\* \* \* \* \* Copy \*\*  
*616046  
Gordon  
Miller  
Gordon  
Miller  
Gordon  
Miller*

- 1. Required fields are: Invoice date, Invoice number, Vendor name.
- 2. Address is required if there is no invoice.
- 3. In all cases if a P.O. was used it must be noted.

**I PAYEE INFORMATION** (Check one only)  Vendor  Patient

Invoice Date <b>September 24, 2008</b>	Invoice Number	PO #
Vendor Name <b>Glenda Coleman-Miller (Employee #</b>		Vendor Number
Address <b>s.17(1), 17(4)(g)(i)</b>		City
Province/State	Postal Code	Country

- 4. Complete entire section.
- 5. CMS contract number is provided by CCO.
- 6. The exemption numbers are assigned by Accounting Services
- 7. For invoices with a purchase order, only invoice total is required.

**II PAYMENT DETAILS** Reason for payment: **Reimbursement of meal costs for Speaking of Women's Health**

**Conference Planning Committee meetings (Sept. 09 + Sept. 11/08)** - Participants: - Co chairs (Donna Sarah Jarne)  
- P. Bremer  
- G. Coleman-Miller  
- W. Mistry  
- Volunteers (FHA)

Is this a P.O. or contract payment?  Yes  No

If this purchase requires a contract and you do not have a CMS contract number, please contact Corporate Contracting Office (CCO) CMS (Contract Management System) Contract Number

If **not** a contract or PO purchase, does it comply with items under CAD 4.4.1 Section A, 6 (f) Page 2  
 **Yes describe 6(f) catering**  No, exemption # - -

Goods / services have been received, price agrees to contract or P.O. as applicable and calculation is correct (Items were received as ordered, are in good condition, will be used by department and pricing/calculations checked)  
 Yes,  No Explain Below

Explanation:

Are original attachments to be mailed with cheque? (Note 2)  Yes  No

- 8. All fields are required if there is no purchase order.
- 9 All codes must be Oracle codes - do not use Vax or Tandem codes.
- 10. Check with Business Support for available codes.

**III EXPENSE CODES (IN ORACLE FINANCIAL SYSTEM FORMAT)**  
(Departments must provide Complete Coding)

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Expense Sub-Total	GST if applicable	Total Payment
<b>201</b>	<b>0002</b>	<b>71558000206</b>	<del>62410000</del>	<b>\$410.00</b>		<b>\$410.00</b>
			<del>62300000</del>			

Currency (select one)  
 Canadian  U.S.  Other

<b>TOTAL</b>	<b>\$410.00</b>			<b>\$410.00</b>
--------------	-----------------	--	--	-----------------

- 11. This section is required for all payments.
- 12. Approver should not be requisitioner unless no other person is available.
- 13. Approver confirms that this payment has not already been made.

**IV AUTHORIZATION**

I confirm that the above items have not been previously paid, the expenses relate only to Capital Health business and information provided on this form is accurate and complete.

Requisitioned by (Print name) <b>Desiree Olafson</b>	(Signature) <i>[Signature]</i>	Phone # <b>735-5779</b>
Title: <b>Executive Secretary, RAH Administration</b>		Date <b>Sept. 24/08</b>
Approved by (Print name) <b>Joanna Pawlyshyn</b>	(Signature) <i>[Signature]</i>	Phone # <b>735-4101</b>
Title: <b>VP &amp; COO, RAH and Lab Services</b>		Date
Approved by (Print name)	(Signature)	Phone #
Title:	Signing Authority Level #	Date

**AUTHORIZATIONS SHOULD BE IN ACCORDANCE WITH SIGNING AUTHORITY POLICY NUMBER FINANCE 4.1 - SEE PAGE 2 FOR DETAILS**

- Notes:
- 1) All employee claims must be submitted on the Travel & Employee Expense Claim form
  - 2) All cheques and attachments will be mailed out by Accounting Services. Cheques will **NOT** be pulled and returned to departments for mailing.
  - 3) Fully completed payment requisitions received in Accounting Services by **MONDAY, 4:00 p.m.** will be processed that week.
  - 4) **Incomplete/improperly authorized payment requisitions will be returned without processing**

*44*

# APPLICANT COPY

Guidance for Approval of Invoice Payments  
 Note: Refer to CAD if payment is for  
 or Non Hospital Surgical Facilities

– Excerpt from Delegations of Signing Authorities CAD 4.4.1  
 Equipment, Information Systems, Physicians or Community Contracted Agencies

Authority Levels			
Level 1 Board			
Level 2 President			
Level 3 Executive Vice President, Finance			
Level 4 COO, VP, CIO, CPO, CLO, etc.	Administration and CFO		
Level 5 SOO, Regional Director, Senior	Equivalent approved by Level 3)		
Level 6 Director or equivalent	or equivalent		
Level 7 Manager or equivalent			
Level 8 Coordinator, Supervisor or equivalent			
Level 9 Business Support Directors/	Directors		
		Authority Level	Limits (Cdn \$)
<b>Approval for invoice payments</b>			
6(c) Payments for consulting and	under contract	<ul style="list-style-type: none"> <li>• Level 2, Level 3</li> <li>• Level 3 and Level 4</li> <li>• Level 4</li> <li>• Level 5</li> <li>• Level 6</li> <li>• Level 7</li> </ul>	None \$1,000,000 \$ 500,000 \$ 250,000 \$ 100,000 \$ 50,000
6(f) Items not requiring purchase	under contract term space rental and related items e.g. equipment rental supplies rentals s ational training, Seminars, web access ges nes, credit checks rinted educational materials dvertising under \$200 (excluding-cash/near cash items) g agencies ursements for personal property ls, as per approval levels described in Section H Trust payments ste removal and shredding owing for Capital Health vehicles vices for CH employees to access CH network OG, EEG, etc. where approved regional rates are maintenance alth vehicles on 7 for signing levels s & sewer – see section 8 for signing levels n, mileage & expenses – see section 9 for s – see section 10 for approval levels ones listed, as approved by the Director	<ul style="list-style-type: none"> <li>• Level 2, Level 3</li> <li>• Level 4 with Level 3</li> <li>• Level 4</li> <li>• Level 5</li> <li>• Level 6</li> <li>• Level 7</li> </ul>	None \$ 100,000 \$ 20,000 \$ 10,000 \$ 5,000 \$ 1,000
		<b>No other payments without contracts or PO's will be allowed</b>	



# APPLICANT COPY

## Travel & Employee Expense Claim Form

(In Canadian Dollars) s.17(1), 17(4)(g)(i)

Name: Glenda Coleman-Miller	Employee Number:	Union Name:
Position: Senior Operating Officer	Department: Executive	
Business Phone: 735-5271	Period From: September 9 to September 11, 2008	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0002	71558000206	62410000			\$410.00	<input checked="" type="checkbox"/>
		(Speaking of women's Health Conf. Acct.)					<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
Total						\$410.00	<input checked="" type="checkbox"/>

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature:

*Glenda Coleman-Miller*

Date: September 19, 2008

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: (Print name)	Title:	Phone #
(Signature)		Date
Approved By: (Print name)	Title:	Phone #
(Signature)		Date

**NOTE:**

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
- GST amounts included in the expense claims will be calculated by Accounts Payable.
- Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
- For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
- For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
- See page 2 of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP



<b>Recommended Coding</b>							
<ul style="list-style-type: none"> <li>• Local Travel – Staff - 62410000</li> <li>• Staff Local Travel – Taxi – 62410001</li> <li>• Staff Travel – UNA – 62410002</li> <li>• Staff Provincial Travel – 62412000 (all expenses)</li> <li>• Staff Out of Province Travel – 62414000 (all expenses)</li> </ul>				<ul style="list-style-type: none"> <li>• Catering – 69600000</li> <li>• Meals - 62410000</li> <li>• Mileage – 62410000</li> <li>• Course Registration &amp; Materials – 61030000</li> </ul>			
Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
Sept. 2008	Pizza Dinner for SOWH Volunteers - 9/9 and 9/11/08		\$410.00				
<b>Total km</b>							
<b>Rate as outlined in Section 2 – Travel below @</b>							
<b>Totals</b>			\$410.00				

**EXPENSE LIMITS**

**1. Meal Allowances**

When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:

- Breakfast \$8.50 (if the departure time is earlier or the return time is later than 7:30 a.m.)
- Lunch \$10.75 (if the departure time is earlier or the return time is later than 1:00 p.m.)
- Dinner \$19.20 (if the departure time is earlier or the return time is later than 6:30 p.m.)

For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.

Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.

**2. Travel**

- Use of personal automobile – From March 1, 2006, reimbursement at the general rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
- Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
- Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
  - 1. Monthly travel in excess of 340 kilometers; or
  - 2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
  - 3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
- If union contract rate differs from \$0.43 then contract rate must be used.
- Includes all forms of transportation costs, including taxis and buses for local travel.
- Driving to and from work is not considered business travel and cannot be claimed.

**3. Advance**

Travel advance may be requested provided travel expenses are likely to exceed \$500.

Hollywood Pizza  
~~11745-845~~  
 DATE Sept 11 20 08

M	ACCT. FWD.
1	
2	
3	
4	1/6 Large
5	to Home 67.50
6	5 pepperoni 56.25
7	
8	5 pepperoni
9	(FT) 61.25
10	
11	
12	
13	
14	185.00
15	

PRICE PER 1 & PRODUCE PRODUCTS  
 TO REC: 1 PHONE 449-1040 OR FAX 474-3002

s.17(1), 17(4)(c.1)

DO NOT WRITE ABOVE THIS LINE - NE RIEN ÉCRIRE AU-DESSUS DE CETTE LIGNE

9 COLLEGE MILLS

01/08

SALES DEPT CHARGES FACTURE

CARDHOLDER'S SIGNATURE/SIGNATURE DU TITULAIRE  
*Shirley Miller*

DATE OF PURCHASE/DATE D'ACHAT  
 09/11/08

AMOUNT/MONTANT  
 5 735

DESCRIPTION	AMOUNT/MONTANT
Thank You	\$185.00
	80.00
CAN \$205.10	

DATE EXPIRES/DATE D'ÉCHÉANCE  
 09/11/08

DATE CHECKED/DATE VÉRIFIÉE  
 09/11/08

AMOUNT TAKEN/AMOUNT PRELEVÉ  
 185.00

AMOUNT EMPLOYED/AMOUNT EMPLOYÉ  
 0.00

DATE OF DEBIT/DATE DE DÉBIT  
 09/11/08

DEBITED/DEBITÉ  
 185.00

CUSTOMER COPY  
 COPIE DU CLIENT

Official Mark Charader Olympic Association  
 Marque officielle Association Olympique canadienne

Cardholder will pay to the issuer of the charge card presented herewith the amount stated herein in accordance with the issuer's agreement with the cardholder.  
 Le titulaire de la carte de charge présentée par lui à l'émission de la carte s'engage à régler le montant au fournisseur des conditions de la convention émise.

APPLICANT COPY

Hollywood Pizza

TRAC 11745-845K

DATE Sept 9 2008

M	ACCT. FWD.
1	6L / Ham 67.50
2	
3	
4	5L / pepperoni 56.25
5	
6	
7	5L / med greeny
8	
9	
10	FROM 61.25
11	
12	
13	
14	185.00
15	40

PRICE PAPER & PRODUCE PRODUCTS  
TO REORDER PHONE 449-1040 OR FAX 474-3002

11/08

DE CETTE LIGNE \$17(1), 17(4)(e.1)

DESCRIPTION	AMOUNT	AMOUNT-MONTANT
	5.733	
	\$185.00	
	20.10	
	205.77	

DATE D'EXPIRATION: 09/09/08

CLIENT: [Signature]

AMOUNT: 5.733

AMOUNT-MONTANT: \$185.00

SALES DRAFT CHARGES FACTURE: 20.10

CAN \$ 205.77

CUSTOMER COPY  
COPIE DU CLIENT

Official Mark Canadian Olympic Association  
Marque officielle Association olympique canadienne

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003

61.25 +

56.25

67.50

20.10

205.77

11.25

6.00

57.50

0.00

11.25

5.00

56.25

0.00

12.25

5.00

61.25

0.00

0.00

**Travel & Employee Expense Claim Form**
*(In Canadian Dollars)* s.17(1), 17(4)(g)(i)

<b>Name:</b> Glenda Coleman-Miller	<b>Employee Number:</b>	<b>Union Name:</b>
<b>Position:</b> Vice President	<b>Department:</b> Site Administration	
<b>Business Phone:</b> 407-8009	<b>Period From:</b> March 2009 <b>to</b> June 2009	

**Expenses Paid (please attach receipts). Do not include amounts paid by Alberta Health Services or reimbursed / reimbursable by another organization. Complete details on the other side of the form**


Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0001	71110101008	62400004			\$20.00	<input checked="" type="checkbox"/>
201	0001	71110101008	62412000			655.12	<input type="checkbox"/>
201	0001	71110101008	62412000			168.24	<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
<b>Less Cash Advance</b>							<input type="checkbox"/>
<b>Total</b>						\$843.36	<input type="checkbox"/>

Alberta Health Services  
 Accounts Payable  
 JUL 07 2009  
 RECEIVED

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Alberta Health Services business and have not been previously claimed by me or on my behalf from Alberta Health Services or other organization.	
<b>Employee Signature:</b> <i>Glenda Coleman-Miller</i>	<b>Date:</b> <i>June 26/09</i>

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

<b>Approved By:</b> Deb Gordon <i>(Print name)</i>	<b>Title:</b> Senior V.P., Major Tertiary Hospitals	<b>Phone #</b> 780-407-2761
<i>(Signature)</i> 		<b>Date</b> <i>02-26-09</i>
<b>Approved By:</b>	<b>Title:</b>	<b>Phone #</b>
<i>(Signature)</i>		<b>Date</b>

**NOTE:**

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
- GST amounts included in the expense claims will be calculated by Accounts Payable.
- Fully completed Travel & Employee Expense Claim forms received in Accounting Services by **Thursday, 4:00 p.m.** will be processed the following week.
- For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
- For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
- See page 2 of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

**APPLICANT COPY  
EXPENSE CLAIM DETAILS**

<b>Recommended Coding</b>							
<ul style="list-style-type: none"> <li>61530030 – Workshop Fees &amp; Materials</li> <li>61520020 – Academic Course Fees &amp; Materials</li> <li>61540040 – Conference Fees &amp; Materials</li> <li>62300000 – Meals</li> <li>62320000 – Staff Local Travel – Client Related</li> <li>62310000 – Staff Local Travel – Non-Client Related</li> <li>62320000 – Staff Local Travel – Taxi – Client Related</li> </ul>				<ul style="list-style-type: none"> <li>62310000 – Staff Local Travel – Taxi – Non-Client Related</li> <li>62320000 – Staff Travel – UNA – Client Related</li> <li>62310000 – Staff Travel – UNA – Non-Client Related</li> <li>62312000 – Staff Provincial Travel – Non-Client Related</li> <li>62314000 – Staff Out of Province Travel – Non-Client Related</li> <li>Catering – 69600000</li> </ul>			
Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
3/13/09	CCHSE Power Breakfast			NT \$20.00			
5/1/09	Site Visit - Foothills (Calgary)				10.00		600
5/15/09	IRSM Tour - MCH				7.00		15
6/9/09	Stollery Foundation Annual Board Mtg				15.00		10
6/10/09	Edm. Clinic Operations				4.50		
6/15/09	ACAC Symposium - Calgary						600
6/18/09	Senior Leadership - Calgary	168.24					
		163.30					
		4.92 NT					
<b>Total km</b>							1225
<b>Rate as outlined in Section 2 – Travel below @</b>							
<b>Totals</b>		\$168.24		\$20.00	\$36.50		\$618.62

**EXPENSE LIMITS**

**1. Meal Allowances**

When traveling on Alberta Health Services business, the employee may be reimbursed at the Per Diem meal allowance of:

- Breakfast \$10.00 (if the departure time is earlier or the return time is later than 7:30 a.m.)
- Lunch \$15.00 (if the departure time is earlier or the return time is later than 1:00 p.m.)
- Dinner \$25.00 (if the departure time is earlier or the return time is later than 6:30 p.m.)

For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.

Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.

**2. Travel**

- Use of personal automobile – From August 1, 2008, reimbursement at the general rate of \$0.505 per km for approved travel in a fiscal year [April 1 to March 31] (except where collective agreement specifies otherwise).
- Business car insurance is reimbursable up to \$500 per year with receipts in accordance with Alberta Health Services Policy.
- Effective August 1, 2008, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
  1. Monthly travel in excess of 340 kilometers; or
  2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
  3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.52 per kilometer.
- If union contract rate differs from \$0.505 then contract rate must be used.
- Includes all forms of transportation costs, including taxis and buses for local travel.
- Driving to and from work is not considered business travel and cannot be claimed.

**3. Advance**

Travel advance may be requested provided travel expenses are likely to exceed \$500.

APPLICANT COPY



Canadian College of  
Health Service Executives  
Collège canadien des  
directeurs de services de santé

**CANADIAN COLLEGE OF HEALTH SERVICE EXECUTIVES  
NORTHERN ALBERTA CHAPTER**

**INVOICE**

March 13, 2009

Glenda Coleman-Millar  
VP Stollery Children's Hospital  
8440 - 112 Street  
Edmonton, AB  
T6G 2B7

Canadian College of Health Services Executives – Power Breakfast – April 7, 2009	\$20.00
	\$0.00
	GST \$0.00
	Courier \$0.00
	<b>TOTAL \$20.00</b>

**Please make cheque payable to:**

Northern Alberta Chapter, CCHSE

\*Please have the persons name added to the Cheque  
so that we can track who to credit for the payment.

**Please send cheque prior to the event to:**

Holly Dahl, Admin. Assistant  
c/o 10R10 Edmonton General Hospital  
Chronic Disease Management  
11111 Jasper Avenue  
Edmonton AB T5K 0L4  
Phone: (780) 413-7748

APPLICANT COPY


0977


GLENDA D COLEMAN-MILLER

DATE 20090313  
Y Y Y Y M M D D

s.17(1), 17(4)(g)(i)

PAY TO THE ORDER OF Northern Alberta Chapter CC #156 \$20.00

Twenty /100 DOLLARS  Security features included. Details on back.

 ROYAL BANK OF CANADA  
MAGRATH HEIGHTS BRANCH  
14155 - 23RD AVE.  
EDMONTON, AB T6R 0G4

MEMO Glenda D. Coleman-Miller

s.17(1), 17(4)(e.1)

# APPLICANT COPY



135 Southland Drive S.E.  
Calgary, Alberta T2J 5X5  
Phone: (403) 278-5050 Fax: (403) 225-5834  
Toll Free Reservations 1 (877) 278-5050  
Email: info@deltacalgarysouth.com  
Web address: www.deltacalgarysouth.com

Room : 0144  
Folio # : 85070  
Invoice # :  
Cashier # : 241  
Page # : 1 of 1  
Group Name : AB HEALTH SERVICES

**AB HEALTH SERVICES**  
Glenda Coleman-Miller  
Royal Alexander Hospital  
Edmonton, AB T5H 3V9  
CA

Arrival : 06-17-09  
Departure : 06-18-09

Description	Additional Information	Charges	Credits
06-17-09 Tower Banquet Wine	Event ID 568283/BB ID 494203/Wine Service 506759585780 AB HEALTH SERVICES #9046=>Coleman-Miller Glenda #0144	<del>26.00</del>	
06-17-09 Room Charge		154.00	
06-17-09 DMF		1.54	
06-17-09 Room GST	s.17(1), 17(4)(e.1)	7.78	
06-17-09 Tourism Levy		6.22	
06-18-09 Visa	XX/XX		195.54

<b>Total</b>	<b>195.54</b>	<b>195.54</b>
<b>Balance Due</b>	<b>0.00</b>	

G.S.T. Summary

Room	7.78
F&B	0.00
Other	0.00
Total	0.00

*#168.24*

*163.32*

Guest Signature X

I have accepted delivery of The Globe and Mail. Had I refused, I would have been eligible for a \$0.75 (Mon-Fri) and \$1.50 (Sat.) credit to my account. (At participating hotels.)

Regardless of charge instructions, I acknowledge the above as personal indebtedness.

E. & OE.



City of Health Region  
 Facilities Management Centre  
 Parking Fee Receipt

APPLICANT COPY  
 05/01/09 16:15 LH 6 hr 4 Term 36383  
 05/01/09 09:34 in 05/01/09 16:15 Out  
 Total Fee \$ 10.00  
 Cash Paid \$ 10.00  
 Total Amount \$ 20.00  
 05/01/09 16:15  
 05/01/09 16:15  
 05/01/09 16:15



NON TRANSFERABLE 37808125  
 CHARGES ARE FOR THE USE OF THE PARKING SPACE ONLY  
 WE WILL NOT BE RESPONSIBLE FOR LOSS OR DAMAGE TO  
 CAR OR CONTENTS, HOWEVER CAUSED, INCLUDING BUT NOT  
 LIMITED TO FIRE, THEFT OR COLLISION

12/05/09 16:08  
 AMOUNT PAID \$ 7.00 36650000 14:08

DISPLAY THIS SIDE UP ON DASHBOARD



RECEIPT 37808125  
 GST# 881490627 RT001

22/05/09 14:00 \$ 7.00  
 DATE ISSUED TIME ISSUED AMOUNT PAID  
 CREDIT CARD NUMBER s.17(1), 17(4)(e.1)

DETACH RECEIPT FROM TICKET

TICKET VOID IF RE-SOLD

IMPARK EDMONTON  
 OVERNIGHT PARKING  
 1230101  
 IMPARK

PLACE THIS SIDE UP ON DASH

TICKET VOID IF RE-SOLD

Price: \$19.00  
 Card: VISA  
 EXPIRATION TIME:  
 Jun 10 2:00 AM Wed  
 6:00 AM  
 GST NO. 887315638 RT0001  
 This receipt is  
 and Impark database

PLACE THIS SIDE UP ON DASH



UNIVERSITY OF ALBERTA  
 1497049

10/06/09 09:02 AM  
 AMOUNT PAID \$ 4.50 15120000 07:54 AM

DISPLAY THIS SIDE UP ON DASHBOARD



UNIVERSITY OF ALBERTA  
 1497049

10/06/09 07:54 AM \$ 4.50  
 DATE ISSUED TIME ISSUED AMOUNT PAID  
 CREDIT CARD NUMBER Physed 1

DETACH RECEIPT FROM TICKET

# APPLICANT COPY



## Travel & Employee Expense Claim Form

(In Canadian Dollars) 17(1), 17(4)(g)(i)

Name: Glenda Coleman-Miller	Employee Number: _____	Union Name: _____
Position: Vice President	Department: Site Administration	
Business Phone: 407-8009	Period From: July 2009 to September 2009	

Expenses Paid (please attach receipts). Do not include amounts paid by Alberta Health Services or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0001	71110101008	62400004			\$224.58	<input checked="" type="checkbox"/>
201	0001	71110101008	62412000			95.00	<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
<b>Total</b>						<b>\$319.58</b>	<input type="checkbox"/>

Alberta Health Services  
 Accounts Payable  
 OCT 13 2009  
**RECEIVED**

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Alberta Health Services business and have not been previously claimed by me or on my behalf from Alberta Health Services or other organization.

Employee Signature: Glenda Coleman-Miller Date: October 13/09

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: Deb Gordon <small>(Print name)</small>	Title: Senior V.P., Major Tertiary Hospitals	Phone # 780-407-2761
(Signature) <u>[Signature]</u>		Date <u>OCT 13/09</u>
Approved By:	Title:	Phone #
(Signature)		Date

**NOTE:**

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
- GST amounts included in the expense claims will be calculated by Accounts Payable.
- Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
- For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
- For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
- See page 2 of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

**APPLICANT COPY  
EXPENSE CLAIM DETAILS**

**Recommended Coding**

- 61530030 – Workshop Fees & Materials
- 61520020 – Academic Course Fees & Materials
- 61540040 – Conference Fees & Materials
- 62300000 – Meals
- 62320000 – Staff Local Travel – Client Related
- 62310000 – Staff Local Travel – Non-Client Related
- 62320000 – Staff Local Travel – Taxi – Client Related
- 62310000 – Staff Local Travel – Taxi – Non-Client Related
- 62320000 – Staff Travel – UNA – Client Related
- 62310000 – Staff Travel – UNA – Non-Client Related
- 62312000 – Staff Provincial Travel – Non-Client Related
- 62314000 – Staff Out of Province Travel – Non-Client Related
- Catering – 69600000

Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
7/10/09	Parking - Acute care Capital Planning				\$10.00		
7/8/09	Parking - U of A ECN Animation				8.00		
9/24/09	Cab Fare - Airport Edm. - SVP/VP Mtg.				52.00		
9/25/09	Cab Fare - Airport Calg. - SVP/VP Mtg	0.00			25.00		
9/25/09	Hotel - SVP/VP Mtg - Calgary	224.58					
<b>Total km</b>							
<b>Rate as outlined in Section 2 – Travel below @</b>							
<b>Totals</b>		\$224.58			\$95.00		

**EXPENSE LIMITS**

**1. Meal Allowances**

When traveling on Alberta Health Services business, the employee may be reimbursed at the Per Diem meal allowance of:

- Breakfast \$10.00 (if the departure time is earlier or the return time is later than 7:30 a.m.)
- Lunch \$15.00 (if the departure time is earlier or the return time is later than 1:00 p.m.)
- Dinner \$25.00 (if the departure time is earlier or the return time is later than 6:30 p.m.)

For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.

Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.

**2. Travel**

- Use of personal automobile – From August 1, 2008, reimbursement at the general rate of \$0.505 per km for approved travel in a fiscal year [April 1 to March 31] (except where collective agreement specifies otherwise).
- Business car insurance is reimbursable up to \$500 per year with receipts in accordance with Alberta Health Services Policy.
- Effective August 1, 2008, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
  1. Monthly travel in excess of 340 kilometers; or
  2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
  3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.52 per kilometer.
- If union contract rate differs from \$0.505 then contract rate must be used.
- Includes all forms of transportation costs, including taxis and buses for local travel.
- Driving to and from work is not considered business travel and cannot be claimed.

**3. Advance**

Travel advance may be requested provided travel expenses are likely to exceed \$500.

APPLICANT COPY



2001 Airport Road N.E.  
 Calgary, AB T2E 6Z8  
 Telephone: (403) 291-2600 Fax: (403) 250-6121

Room : 849  
 Folio No. :  
 Cashier No. : 20  
 Page No. : 1 of 1

Glenda Colemanmiller

Arrival : 09-24-09  
 Departure : 09-25-09

Date	Description	Additional Information	Charges	Credits
09-24-09		Non-Responsive	<del>72.31</del>	<i>not claimed</i>
09-24-09	Room Charge		204.00	
09-24-09	Room Destination Marketing Fe		2.04	
09-24-09	Room Tourism Levy		8.24	
09-24-09	Room GST		10.30	
<b>Total</b>			<b>296.89</b>	<b>0.00</b>

Balance Due

~~296.89~~  
224.58

<b>GST Summary</b>	<b>GST Redemption#:</b> 846543619
Room	10.30
F&B	3.06
Other	0.00
<b>Total</b>	<b>13.36</b>

Guest Signature X \_\_\_\_\_

I agree that my liability for this bill is not waived and I agree to be held personally liable in the event that the indicated person, company or association fails to pay for any part of or the full amount of these charges.  
 I have accepted delivery of The Globe and Mail. Had I refused, I would have been eligible for a \$.75 (Mon-Fri) and \$1.50 (Sat.) credit to my account. (At participating hotels.)

Driver # \_\_\_\_\_  
 Car # \_\_\_\_\_  
 To: \_\_\_\_\_  
 From: \_\_\_\_\_  
 Date: Sept 25, 09 Amount: 25.00  
 GST # \_\_\_\_\_

APPLICANT COPY **YELLOW CAB**

780-462-3456

GST# 127144236  
 Date: SEP. 24. 09 Amount: 52.00  
 Driver: Sam Car #: 885  
 From: U.A. Hospital  
 To: IAP

10135 - 31 Avenue, Edmonton, AB T6N 1C2

RECEIPT  
 UNIVERSITY OF ALBERTA  
 GST # R108102831  
 1528977  
 DATE ISSUED: 08/07/09 08:59 AM \$ 8.00  
 TIME ISSUED: 08/07/09 08:59 AM \$ 8.00  
 AMOUNT PAID: 17(1), 17(4)(e.1)  
 PHYSICAL NUMBER: 17(1), 17(4)(e.1)  
 DETACH RECEIPT FROM TICKET

NON TRANSFERABLE  
 UNIVERSITY OF ALBERTA  
 1528977  
 EXPIRATION DATE: 08/07 08:59 AM  
 EXPIRATION TIME: 08/07 08:59 AM  
 AMOUNT PAID: \$ 8.00 1512000007:59 AM  
 DISPLAY THIS SIDE UP ON DASHBOARD

s.17(1), 17(4)(e.1)

PLACE FACE UP ON DASH  
 Impark Lot 256  
 Expiration Date/Time  
**EXP 10:57AM**  
**JUL 10, 2009**

Purchase Date/Time: 08:57am Jul 10, 2009  
 Total Due: \$10.00  
 Total Paid: \$10.00  
 Visa  
 Rate: \$10 - 2 Hour  
 Payment Type: Card  
 Ticket #: 10837051  
 Auth #: 006723  
 S/N #: 100006440038  
 Setting: Lot 256  
 GST #667316338R10001

RECEIPT

Impark Lot 256  
 Expiration Date/Time: 10:57am Jul 10, 2009  
 Purchase Date/Time: 08:57am Jul 10, 2009  
 Total Due: \$10.00  
 Total Paid: \$10.00  
 Visa  
 Rate: \$10 - 2 Hour  
 Payment Type: Card  
 Ticket #: 10837051  
 Auth #: 006723  
 Setting: Lot 256

**Travel & Employee Expense Claim Form**  
(In Canadian Dollars)

s.17(1), 17(4)(g)(i)

Name: Glenda Coleman-Miller		Employee Number:	Union Name:
Position: Vice President		Department: Administration	
Business Phone: 780-407-8009		Period From: October/09 to May /10	

Expenses Paid (please attach receipts). Do not include amounts paid by Alberta Health Services or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included	
201	0001	71110101008	62310000			\$127.50	<input type="checkbox"/>	
							<input type="checkbox"/>	
							<input type="checkbox"/>	
							<input type="checkbox"/>	
							<input type="checkbox"/>	
							<input type="checkbox"/>	
Less Cash Advance							<input type="checkbox"/>	
Total							127.50	<input type="checkbox"/>

RECEIVED  
MAY 17 2010  
Accounts Payable

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Alberta Health Services business and have not been previously claimed by me or on my behalf from Alberta Health Services or other organization.

Employee Signature: <i>[Signature]</i>	Date: May 18/10
--	-----------------

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: Deb Gordon (Print name)	Title: SVP, Major Tertiary Hospitals	Phone # 7-2761
(Signature) <i>[Signature]</i>		Date May 25/10
Approved By:	Title:	Phone #
(Signature) <i>[Signature]</i>		Date

- NOTE:**
- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
  - GST amounts included in the expense claims will be calculated by Accounts Payable.
  - Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
  - For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
  - For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
  - See page 2 of this form for expense claim limits.
  - Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower, 107 Street, Edmonton, AB T5J 3E4)
  - Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or

RECEIVED  
MAY 21 2010  
MAJOR TERTIARY HOSPITALS

**APPLICANT COPY**  
**EXPENSE CLAIM DETAILS**

**Recommended Coding**

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>• 61530030 – Workshop Fees &amp; Materials</li> <li>• 61520020 – Academic Course Fees &amp; Materials</li> <li>• 61540040 – Conference Fees &amp; Materials</li> <li>• 62300000 – Meals</li> <li>• 62320000 – Staff Local Travel – Client Related</li> <li>• 62310000 – Staff Local Travel – Non-Client Related</li> <li>• 62320000 – Staff Local Travel – Taxi – Client Related</li> </ul> | <ul style="list-style-type: none"> <li>• 62310000 – Staff Local Travel – Taxi – Non-Client Related</li> <li>• 62320000 – Staff Travel – UNA – Client Related</li> <li>• 62310000 – Staff Travel – UNA – Non-Client Related</li> <li>• 62312000 – Staff Provincial Travel – Non-Client Related</li> <li>• 62314000 – Staff Out of Province Travel – Non-Client Related</li> <li>• Catering – 69600000</li> </ul> |
|--|---|

Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
Oct. 6/09	Parking				\$15.00		
Oct. 7/09	Parking				8.00		
Oct. 28/10	Parking				4.00		
Dec. 8/10	Parking				20.00		
Dec. 16/10	Parking				18.00		
Jan 8/10	Parking				19.00		
Mar. 18/10	Parking				9.00		
Apr 8/10	Taxi				17.00		
Apr 28/10	Parking				6.00		
Apr. 30/10	Parking				6.00		
May 12/10	Parking				5.50		
							<b>Total km</b>
<b>Rate as outlined in Section 2 – Travel below @</b>							
<b>Totals</b>					127.50		

**EXPENSE LIMITS**

**1. Meal Allowances**

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- Lunch \$15.00 (if the departure time is earlier or the return time is later than 1:00 p.m.)
- Dinner \$25.00 (if the departure time is earlier or the return time is later than 6:30 p.m.)

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- Business car insurance is reimbursable up to \$500 per year with receipts in accordance with Alberta Health Services Policy.
- Effective August 1, 2008, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
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  2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
  3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.52 per kilometer.
- If union contract rate differs from \$0.505 then contract rate must be used.
- Includes all forms of transportation costs, including taxis and buses for local travel.
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**3. Advance**

Travel advance may be requested provided travel expenses are likely to exceed \$500.

Edmonton Airports

Can- Edmonton  
Tax CodeCA5%

POF 2nd Fl 08/12/09 19:19  
Receipt 068823

Short-term parking tkt  
 DL - No. 092418  
 08/12/09 04:49 -  
 08/12/09 19:19 -  
 Period 0d14h31'  
 (Tax) \$20.00  
 Total \$20.00  
 Payment Received  
 Cash \$20.00  
 Sub Total \$19.05  
 Tax 5% 0.95

**LEAVE ON DASH - THIS SIDE UP**  
 EXPIRATION DATE 06/10/09 EXPIRATION TIME 11:03 AM  
 AMOUNT PAID \$ 15.00 23270000 RAH 11:03 AM

Alberta Health Services  
 CHARGES ARE FOR USE OF PARKING SPACE ONLY. ALBERTA HEALTH SERVICES ENDEAVOURS TO PROTECT THE PROPERTY OF ITS PATRONS BUT WILL NOT BE RESPONSIBLE FOR LOSS OR DAMAGE TO CAR OR CONTENTS.  
 NON TRANSFERABLE 490013

**DETACH RECEIPT FROM TICKET**  
 DATE ISSUED 06/10/09 TIME ISSUED 11:03 AM AMOUNT PAID \$ 15.00  
 CREDIT CARD NUMBER

Alberta Health Services  
**RECEIPT 490013**

**LEAVE ON DASH - THIS SIDE UP**  
 EXPIRATION DATE 07/10/09 EXPIRATION TIME 11:05 AM  
 AMOUNT PAID \$ 8.00 23270000 RAH 09:05 AM

Alberta Health Services  
 CHARGES ARE FOR USE OF PARKING SPACE ONLY. ALBERTA HEALTH SERVICES ENDEAVOURS TO PROTECT THE PROPERTY OF ITS PATRONS BUT WILL NOT BE RESPONSIBLE FOR LOSS OR DAMAGE TO CAR OR CONTENTS.  
 NON TRANSFERABLE 490277

**DETACH RECEIPT FROM TICKET**  
 DATE ISSUED 07/10/09 TIME ISSUED 09:05 AM AMOUNT PAID \$ 8.00  
 CREDIT CARD NUMBER

Alberta Health Services  
**RECEIPT 490277**

**DISPLAY THIS SIDE UP ON DASHBOARD**  
 EXPIRATION DATE 07/10/09 EXPIRATION TIME 08:57 AM  
 AMOUNT PAID \$ 4.00 15120000 07:57 AM

 **UNIVERSITY OF ALBERTA**  
 NON TRANSFERABLE 1839969

**DETACH RECEIPT FROM TICKET**  
 DATE ISSUED 07/10/09 TIME ISSUED 07:57 AM AMOUNT PAID \$ 4.00  
 CREDIT CARD NUMBER s.17(1), 17(4)(e.1)  
 PhysEd 1

 **UNIVERSITY OF ALBERTA**  
**RECEIPT GST # R108102831 1839969**

Auth #: 014626  
 Setting: Lot 256  
 Expiration Date/Time: 03:05pm Dec 16, 2009  
 Purchase Date/Time: 12:05pm Dec 16, 2009  
 Total Due: \$18.00  
 Total Paid: \$18.00  
 Visa  
 Rate: \$18 - 3 Hrs  
 Payment Type: C  
 Ticket #: 8212

Auth #: 014626  
 S/N #: 100008440038  
 Setting: Lot 256  
 GST #887316638R10001  
 Ticket #: 8202  
 Expiration Date/Time: 03:05PM Dec 16, 2009  
 Purchase Date/Time: 12:05pm Dec 16, 2009  
 Total Due: \$18.00  
 Total Paid: \$18.00  
 Visa  
 Rate: \$18 - 3 Hrs  
 Payment Type: C

**PLACE FACE UP ON DASH**  
**EXP 03:05PM**  
**DEC 16, 2009**  
 Expiration Date/Time  
 Impark Lot 256  
 s.17(1), 17(4)(e.1)

PARKING RECEIPT  
 PARKING RECEIPT  
 PARKING RECEIPT  
 PARKING RECEIPT



PLACE FACE UP ON DASH  
Impark Lot 256

EXP 06:00AM  
JAN 08, 2010

Purchase Date/Time: 08:07am Jan 07, 2010  
Total Due: \$19.00  
Rate: \$19 - Early Bird  
Total Paid: \$19.00  
Payment Type: Card  
Auth #: 044923  
SN #: 80008440038  
Setting: Lot 256  
Ticket #: 8307171

s.17(1), 17(4)(e.1)

RECEIPT  
Impark Lot 256

Expiration Date/Time: 06:00am Jan 08, 2010  
Purchase Date/Time: 08:07am Jan 07, 2010  
Total Due: \$19.00  
Rate: \$19 - Early Bird  
Total Paid: \$19.00  
Payment Type: Card  
Auth #: 044923  
SN #: 80008440038  
Setting: Lot 256  
Ticket #: 8307171

PLACE FACE UP ON DASH  
Impark Lot 161

EXP 06:00PM  
MAR 18, 2010

Purchase Date/Time: 07:13am Mar 18, 2010  
Total Due: \$9.00  
Rate: \$9 - Early Bird  
Total Paid: \$9.00  
Payment Type: Card  
Auth #: 046233  
SN #: 80008446606  
Setting: Lot 161  
Ticket #: 01380841

s.17(1), 17(4)(e.1)

RECEIPT  
Impark Lot 161

Expiration Date/Time: 06:00pm Mar 19, 2010  
Purchase Date/Time: 07:13am Mar 18, 2010  
Total Due: \$9.00  
Rate: \$9 - Early Bird  
Total Paid: \$9.00  
Payment Type: Card  
Auth #: 046233  
SN #: 80008446606  
Setting: Lot 161  
Ticket #: 01380841

PLACE FACE UP ON DASH  
Impark Lot 256

EXP 02:30PM  
APR 28, 2010

Purchase Date/Time: 02:20pm Apr 28, 2010  
Total Due: \$6.00  
Rate: \$6 - 1 Hour  
Total Paid: \$6.00  
Payment Type: Card  
Auth #: 052711  
SN #: 80008440038  
Setting: Lot 256  
Ticket #: 4007827

s.17(1), 17(4)(e.1)

RECEIPT  
Impark Lot 256

Expiration Date/Time: 03:04pm Apr 30, 2010  
Purchase Date/Time: 02:20pm Apr 30, 2010  
Total Due: \$6.00  
Rate: \$6 - 1 Hour  
Total Paid: \$6.00  
Payment Type: Card  
Auth #: 052711  
SN #: 80008440038  
Setting: Lot 256  
Ticket #: 4007827

PLACE FACE UP ON DASH  
Impark Lot 256

EXP 03:04PM  
APR 30, 2010

Purchase Date/Time: 02:24pm Apr 30, 2010  
Total Due: \$6.00  
Rate: \$6 - 1 Hour  
Total Paid: \$6.00  
Payment Type: Card  
Auth #: 052711  
SN #: 80008440038  
Setting: Lot 256  
Ticket #: 4007827

s.17(1), 17(4)(e.1)

RECEIPT  
Impark Lot 256

Expiration Date/Time: 03:04pm Apr 30, 2010  
Purchase Date/Time: 02:24pm Apr 30, 2010  
Total Due: \$6.00  
Rate: \$6 - 1 Hour  
Total Paid: \$6.00  
Payment Type: Card  
Auth #: 052711  
SN #: 80008440038  
Setting: Lot 256  
Ticket #: 4007827

APPLICANT COPY  
Impark Lot 256  
Ticket #: 8307171  
Auth #: 044923  
SN #: 80008440038  
Setting: Lot 256

Impark Lot 161  
Ticket #: 01380841  
Auth #: 046233  
SN #: 80008446606  
Setting: Lot 161

Impark Lot 256  
Ticket #: 4007827  
Auth #: 052711  
SN #: 80008440038  
Setting: Lot 256

Impark Lot 256  
Ticket #: 4007827  
Auth #: 052711  
SN #: 80008440038  
Setting: Lot 256

APPLICANT COPY

780-462-3456

GST# \_\_\_\_\_  
Date: 08-04-10 Amount: 17-  
Driver: \_\_\_\_\_ Car #: 142  
From: \_\_\_\_\_  
To: \_\_\_\_\_  
10135 - 31 Avenue, Edmonton, AB T6N 1C2

DETACH RECEIPT FROM TICKET

DISPLAY THIS SIDE UP ON DASHBOARD

DATE ISSUED TIME ISSUED AMOUNT PAID  
08/04/10 07:25 AM \$19.00

EXPIRATION DATE EXPIRATION TIME  
08/04/10 06:00 AM

AMOUNT PAID  
\$19.00

CHARGES ARE FOR THE USE OF THE PARKING SPACE ONLY.  
WE WILL NOT BE RESPONSIBLE FOR LOSS OR DAMAGE TO  
YOUR CAR OR CONTENTS, HOWEVER CAUSED, INCLUDING BUT NOT  
LIMITED TO FIRE, THEFT OR COLLISION.

RECEIPT  
74573574

PRECISE PARKLINK

NON TRANSFERABLE  
74573574

PRECISE PARKLINK

APPLICANT COPY

RECEIVED  
JUL 08 2010  
MAJOR TERTIARY HOSPITALS



Travel & Employee Expense Claim Form  
(In Canadian Dollars) s.17(1), 17(4)(g)(i)

Name: Glenda Coleman-Miller	Employee Number:	Union Name:
Position: Vice President	Department: Site Administration	
Business Phone: 780-407-8009	Period From: June 7	to June 15, 2010

Expenses Paid (please attach receipts). Do not include amounts paid by Alberta Health Services or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0001	71110101008	6231400			\$1,037.08	<input type="checkbox"/>
201	0001	2110101001	6231200			209.00	<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
Total						\$1,246.08	<input type="checkbox"/>

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Alberta Health Services business and have not been previously claimed by me or on my behalf from Alberta Health Services or other organization.

Employee Signature: *bcn* Date: July 6/10

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: Deb Gordon (Print name)	Title: Senior Vice President	Phone # 407-2761
(Signature) <i>Deb Gordon</i>		Date 09 JUL 10
Approved By:	Title:	Phone #
(Signature)		Date

NOTE:

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
- GST amounts included in the expense claims will be calculated by Accounts Payable.
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- For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
- See page 2 of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

**APPLICANT COPY**  
EXPENSE CLAIM DETAILS

**Recommended Coding**

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>• 61530030 – Workshop Fees &amp; Materials</li> <li>• 61520020 – Academic Course Fees &amp; Materials</li> <li>• 61540040 – Conference Fees &amp; Materials</li> <li>• 62300000 – Meals</li> <li>• 62320000 – Staff Local Travel – Client Related</li> <li>• 62310000 – Staff Local Travel – Non-Client Related</li> <li>• 62320000 – Staff Local Travel – Taxi – Client Related</li> </ul> | <ul style="list-style-type: none"> <li>• 62310000 – Staff Local Travel – Taxi – Non-Client Related</li> <li>• 62320000 – Staff Travel – UNA – Client Related</li> <li>• 62310000 – Staff Travel – UNA – Non-Client Related</li> <li>• 62312000 – Staff Provincial Travel – Non-Client Related</li> <li>• 62314000 – Staff Out of Province Travel – Non-Client Related</li> <li>• Catering – 69600000</li> </ul> |
|--|---|

Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage
6/13 - 6/15	Taxi Fares, LEAN Conf. and Calgary meeting				\$209.00		
6/13/10	Accommodation for LEAN Conf - Florida	794.87					
6/15/10	Accommodation, Calgary Child Health and VP Mtg.	242.21					
<b>Total km</b>							
<b>Rate as outlined in Section 2 – Travel below @</b>							
<b>Totals</b>		\$1,037.08			\$209.00		

**EXPENSE LIMITS**

1. **Meal Allowances**  
 When traveling on Alberta Health Services business, the employee may be reimbursed at the Per Diem meal allowance of:
 

Breakfast	\$10.00 (if the departure time is earlier or the return time is later than 7:30 a.m.)
Lunch	\$15.00 (if the departure time is earlier or the return time is later than 1:00 p.m.)
Dinner	\$25.00 (if the departure time is earlier or the return time is later than 6:30 p.m.)

 For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.  
 Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individual organizations whose representatives attended the lunch/dinner meeting.
  
2. **Travel**
  - Use of personal automobile – From August 1, 2008, reimbursement at the general rate of \$0.505 per km for approved travel in a fiscal year [April 1 to March 31] (except where collective agreement specifies otherwise).
  - Business car insurance is reimbursable up to \$500 per year with receipts in accordance with Alberta Health Services Policy.
  - Effective August 1, 2008, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
    1. Monthly travel in excess of 340 kilometers; or
    2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
    3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.52 per kilometer.
  - If union contract rate differs from \$0.505 then contract rate must be used.
  - Includes all forms of transportation costs, including taxis and buses for local travel.
  - Driving to and from work is not considered business travel and cannot be claimed.
  
3. **Advance**  
 Travel advance may be requested provided travel expenses are likely to exceed \$500.



APPLICANT COPY

Hyatt Regency Orlando International Airport  
 9300 Airport Boulevard  
 Orlando, FL. 32827  
 Tel: (407) 825-1234  
 Fax: (407) 856-1672

INFORMATION INVOICE

Payee Glenda Coleman-Miller  
 8440 112th St  
 Unive Hospital  
 Edmonton AB T6G 2B7  
 Canada

Room No. 6135  
 Arrival 06-07-10  
 Departure 06-13-10  
 Page No. 1 of 2  
 Folio  
 Invoice

Membership  
 Bonus Code  
 Confirmation No. **4024993401**  
 Group Name Lean Enterprise June 1020 Healthcare MTG

Date	Description	Charges	Credits
		Non-Responsive <del>91.68</del>	
06-07-10		109.00	
06-07-10	Group Room	7.09	
06-07-10	Sales Tax	6.54	
06-07-10	Occupancy Tax	9.95	
06-08-10	Guest Room Internet 12:40 Room# 6135 :	4.00	
06-08-10	Bottled Water	109.00	
06-08-10	Group Room	7.09	
06-08-10	Sales Tax	6.54	
06-08-10	Occupancy Tax	4.00	
06-09-10	Bottled Water	31.19	
06-09-10	- In Room Dining Dinner Food Room# 6135 : CHECK# 8492	109.00	
06-09-10	Group Room	7.09	
06-09-10	Sales Tax	6.54	
06-09-10	Occupancy Tax	9.95	
06-10-10	Guest Room Internet 16:43 Room# 6135 :	Non-Responsive <del>79.68</del>	
06-10-10		Non-Responsive <del>16.05</del>	
06-10-10		109.00	
06-10-10	Group Room	7.09	
06-10-10	Sales Tax	6.54	
06-10-10	Occupancy Tax	Non-Responsive <del>50.67</del>	
06-11-10		109.00	
06-11-10	Group Room	7.09	
06-11-10	Sales Tax	6.54	
06-11-10	Occupancy Tax	109.00	
06-12-10	Group Room	7.09	
06-12-10	Sales Tax	6.54	
06-12-10	Occupancy Tax		

APPLICANT COPY.



2001 Airport Road N.E.  
 Calgary, AB T2E 6Z8  
 Telephone: (403) 291-2600 Fax: (403) 250-6121

Room : 725  
 Folio No. :  
 Cashier No. : 11  
 Page No. : 1 of 1

**AB HEALTH SERVICES**  
 Glenda Coleman-Miller  
 Royal Alexander Hospital  
 Room 1108, ATC, 10240 Kingsway  
 Edmonton, AB T5H 3V9

Arrival : 06-14-10  
 Departure : 06-15-10

Date	Description	Additional Information	Charges	Credits
06-14-10	Telephone Local Call	Room	1.25	
06-14-10	Telephone GST		0.06	
06-14-10	Room Charge		219.00	
06-14-10	Room Destination Marketing Fee		2.19	
06-14-10	Room Tourism Levy		8.85	
06-14-10	Room GST		11.06	
<b>Total</b>			<b>242.41</b>	<b>0.00</b>
<b>Balance Due</b>			<b>242.41</b>	

<b>GST Summary</b>	<b>GST Redemption#:</b> 846543619
Room	11.06
F&B	0.00
Other	0.06
<b>Total</b>	<b>11.12</b>

Guest Signature X \_\_\_\_\_

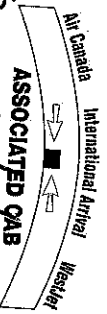
I agree that my liability for this bill is not waived and I agree to be held personally liable in the event that the indicated person, company or association fails to pay for any part of or the full amount of these charges.

I have accepted delivery of The Globe and Mail. Had I refused, I would have been eligible for a \$.75 (Mon-Fri) and \$1.50 (Sat.) credit to my account. (At participating hotels.)

# ASSOCIATED CAB

for all your transportation needs.

Visit our counter at the  
Calgary International Airport  
International arrival floor.



Driver:                      Date: 15/6/10  
Car #: 084 Amount: \$34.00  
GST Included #                     

## APPLICANT COPY

From: Airport Alberta  
To: University of Alberta  
Date: June 15, 2010  
Trip Amount: 52.00  
Driver Name: Spelman  
Car number: 818  
GST:                     

Driver # 5925 Car # 904  
To:                       
From:                       
Date: June 15/10 Amount: 40.00  
GST # 855900908

From: Airport  
To:                       
Time:                       
Date: 13-06-10  
Trip Amount: \$ 55.00  
Driver Name: A-Warshaw  
Car Number: 315  
GST:                     

s.17(1), 17(4)(g)(i)

Date: Jun 14/10

Chauffeur: Bivukic

Unit No.: 1362 Amount: \$40.00  
G.S.T. INCLUDED

G.S.T. No.:

Travel & Employee Expense Claim Form

s.17(1), 17(4)(g)(i)

Out-of-Province Travel: <input type="checkbox"/>	Prior Approval Date (related to Out-of-Province only):	Prior Approved by (related to Out-of-Province only):
Name: <u>Enda Coleman-Miller</u>	Employee #:	Union Name:
Position/Title: <u>Vice President-UAH, Calgary</u>	Department: <u>Site Administration</u>	Location: <u>1F1 WMC</u>
Business Phone #: <u>(780) 407-8009</u>	Travel Period From: <u>July 23, 2010</u> to <u>July 23, 2010</u>	
Which entity payroll system is the employee being paid from? (please check one from below)		
<input type="checkbox"/> Alberta Health Services	<input type="checkbox"/> Calgary Health	<input type="checkbox"/> East Central
<input type="checkbox"/> Alberta Cancer Board	<input checked="" type="checkbox"/> Capital Health	<input type="checkbox"/> Northern Lights
<input type="checkbox"/> Alberta Mental Health Board	<input type="checkbox"/> Chinook	<input type="checkbox"/> Palliser Health
<input type="checkbox"/> Alberta Health Services	<input type="checkbox"/> David Thompson	<input type="checkbox"/> Peace Country

Expenses paid page: Paid (please attach original receipts and retain a copy for your records). Do not include amounts reimbursed by Alberta Health Services or reimbursed / reimbursable by another organization. Complete details on the form.

Summary of Travel & Employee Expenses						
(by Expense Account)						
Category (if applicable)	Finance Code / Accounting Distribution (if applicable)			Non-Canadian Currency	Exchange Rate	Canadian \$
	Location (if applicable)	Functional Centre/Primary	Expense/Secondary Account			
2010	0001	71110101008	61530030			\$266.40
Total						\$278.39

Alberta Health Services  
Accounts Payable  
AUG 31 2010  
RECEIVED

I hereby certify that the expenses listed above are in accordance to applicable policies and were incurred on Alberta Health Services business and have not been previously claimed by me or on my behalf from Alberta Health Services or other organization.

Employee Signature: Enda Coleman-Miller Date: Aug 19/10

I hereby certify that I have reviewed the expenses and that they are in accordance with the applicable policies.

Approved By (please print): <u>Deb Gordon</u>	Title: <u>Senior VP</u>	Phone #: <u>407-2761</u>
Signature: <u>[Signature]</u>		Date: <u>26-AUG-10</u>
Approved By (please print):	Title:	Phone #:
Signature:		Date:

NOTE: This claim must be properly authorized in accordance with Alberta Health Services Policies (i.e. Travel expense with Travel Policy, etc.) and must be supported by original receipts and copy as certified by the approver.

RECEIVED  
AUG 26 2010  
183  
MAJOR TERTIARY HOSPITALS

**EXPENSE CLAIM DETAILS**

Date (DD/MM/YY)	Particulars (Describe Purpose of Trip & Location)	GST \$	Accommodation \$	Meal Type B, L or D	Meals \$	Course Registration & Material \$	Transportation \$	Other \$	Mileage km
23/07/10	Sr Mgt Planning Day with Facilitator Lynn Kirkland @ Derrick Golf & Winter Club	11.99	\$114.70	L	\$151.70				
<b>Total KM</b>									
<b>Applicable Mileage rate @</b>									
<b>Totals</b>		11.99	\$114.70		\$151.70				

Note: Record the total amount for each expense categories from above to the summary table on page 1

APPLICANT COPY

- EXPENSE LIMITS – (Summary information only. Please refer to AHS Travel Policy for terms and conditions.) (Except where collective agreement specifies otherwise).**
- Meal Expenses and Allowances**  
Meal allowances is the actual cost of the meal as shown on the receipt, excluding alcoholic beverages, including up to 15% gratuity, and GST, to a maximum as prescribed below. At discretion of the signing officer, the below maximum meal expense shall also apply where no receipt is available.
    - a) Breakfast = B \$10
    - b) Lunch = L \$12
    - c) Dinner = D \$21
 Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the meeting.
  - Accommodation Expense and Allowances**  
Accommodation expense claims may be made at the actual cost of the room and applicable taxes. The claim is expected to be reasonable given the location and availability of government rates. Accommodation allowance without a receipt is \$20 per night.
  - Travel**
    - Use of personal automobile – Reimbursement at the general rate of \$0.505 per km for approved travel in a fiscal year.
    - Vehicle owners are responsible for any losses that may arise.
    - Business car insurance is reimbursable up to \$500 per year with receipts.
    - Includes all forms of transportation costs, including taxis, air plane and buses for travel related to AHS.
    - Driving from home to a designated work location, and returning home from a designated work location, is not considered business travel and cannot be claimed.
  - Advance**  
Travel advance may be requested provided travel expenses are likely to exceed \$500.







<b>RECEIVED</b> <b>OCT 05 2010</b> MAJOR TERTIARY HOSPITALS
---

<b>Out-of-Province Travel:</b> <input type="checkbox"/>	<b>Prior Approval Date</b> (related to Out-of-Province only): S. 17(1), 17(4)(g)(i)	<b>Prior Approved by</b> (related to Out-of-Province only):
<b>Name:</b> Glenda Coleman-Miller	<b>Employee #:</b>	<b>Union Name:</b>
<b>Position (Title):</b> VP - UAH/Stollery/Maz	<b>Department:</b> Site Administration	<b>Location:</b> 1F1 WMC UAH
<b>Business Phone #:</b> (780) 407-8009	<b>Travel Period From:</b> _____ <b>to</b> _____	
<b>What former entity payroll system is the employee being paid from? (please <input checked="" type="checkbox"/> one from below)</b>		
<input type="checkbox"/> AADAC	<input type="checkbox"/> Calgary Health	<input type="checkbox"/> East Central
<input type="checkbox"/> Alberta Cancer Board	<input checked="" type="checkbox"/> Capital Health	<input type="checkbox"/> Northern Lights
<input type="checkbox"/> Alberta Mental Health Board	<input type="checkbox"/> Chinook	<input type="checkbox"/> Palliser Health
<input type="checkbox"/> Aspen	<input type="checkbox"/> David Thompson	<input type="checkbox"/> Peace Country

Expenses Paid (please attach original receipts and retain a copy for your records). Do not include amounts paid by Alberta Health Services or reimbursed / reimbursable by another organization. Complete details on page 2 of the form.

Summary of Travel & Employee Expenses (by Expense Account)						
Finance Code / Accounting Distribution (if applicable)				Non-Canadian Currency	Exchange Rate	Canadian \$
Corp/BU/Org (if applicable)	Location (if applicable)	Functional Centre/Primary	Expense/Secondary Account			
201	0001	71110101008	61540040			\$344.90
		Alberta Health Services				333.90
		Accounts Payable				
		OCT 12 2010				
		RECEIVED				
<b>Total GST</b>						15.04
<b>Subtotal</b>						<del>359.94</del>
Less Cash Advance (if applicable)						348.99
<b>Total</b>						<del>\$359.94</del>

I hereby certify that the expenses listed above are in accordance to applicable policies and were incurred on Alberta Health Services business and have not been previously claimed by me or on my behalf from Alberta Health Services or other organization.

**Employee Signature:** *Glenda Coleman-Miller* **Date:** *October 4/10*

I hereby certify that I have reviewed the expenses and that they are in accordance with the applicable policies.

<b>Approved By</b> (please print): Deb Gordon	<b>Title:</b> Sr VP - Major Tertiary Hosp	<b>Phone #</b> (780) 407-2671
<b>Signature:</b> <i>[Signature]</i>		<b>Date:</b> <i>06-Oct-10</i>
<b>Approved By</b> (please print):	<b>Title:</b>	<b>Phone #</b>
<b>Signature:</b>		<b>Date:</b>

NOTE: Expense claim must be properly authorized in accordance with Alberta Health Services Policies (i.e. Travel expense in accordance with Travel Policy, etc.) and must be supported by original receipts or a copy as certified by the approver.



**EXPENSE CLAIM DETAILS**

Date (DD/MM/YY)	Particulars (Describe Purpose of Trip & Location)	GST \$	Accommodation \$	Meal Type B, L or D	Meals \$	Course Registration & Material \$	Transportation \$	Other \$	Mileage km
09/14/10	Clinicians Counsell	7.52	\$149.00					\$7.45	
09/15/10	Clinicians Counsell	7.52	149.00	D	32.00			7.45	
<b>Total KM</b>									
<b>Applicable Mileage rate @</b>									
<b>Totals</b>		15.04	\$298.00		32			\$14.90	

Note: Record the total amount for each expense categories from above to the summary table on page 1

APPLICANT COPY

**EXPENSE LIMITS - (Summary information only. Please refer to AHS Travel Policy for terms and conditions.) (Except where collective agreement specifies otherwise).**

**1. Meal Expenses and Allowances**

Meal allowances is the actual cost of the meal as shown on the receipt, excluding alcoholic beverages, including up to 15% gratuity, and GST, to a maximum as prescribed below. At discretion of the signing officer, the below maximum meal expense shall also apply where no receipt is available.

- a) Breakfast = B \$10
- b) Lunch = L \$12
- c) Dinner = D \$21

Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the meeting.

**2. Accommodation Expense and Allowances**

Accommodation expense claims may be made at the actual cost of the room and applicable taxes. The claim is expected to be reasonable given the location and availability of government rates. Accommodation allowance without a receipt is \$20 per night.

**3. Travel**

- Use of personal automobile - Reimbursement at the general rate of \$0.505 per km for approved travel in a fiscal year.
- Vehicle owners are responsible for any losses that may arise.
- Business car insurance is reimbursable up to \$500 per year with receipts.
- Includes all forms of transportation costs, including taxis, air plane and buses for travel related to AHS.
- Driving from home to a designated work location, and returning home from a designated work location, is not considered business travel and cannot be claimed.

**4. Advance**

Travel advance may be requested provided travel expenses are likely to exceed \$500.

Glenda Coleman-Miller

Room No. : 0916  
 Arrival : 09-14-1  
 Departure : 09-16-1  
 Page No. : 1 of 1  
 Folio No. : 759058  
 Conf. No. : 735102  
 Cashier No. : 83  
 09-16-1

**INFORMATION INVOICE**

Membership No. :  
 A/R Number :  
 Group Code : 1009ALBCLI  
 Company Name : Alberta Health Services

Date	Text	Charges	Credits
09-14-10	Room Charge	149.	
09-14-10	Destination Marketing Fee	1.00	
09-14-10	Alberta Tourism Levy	5.00	
09-14-10	Room GST	7.00	
09-15-10	Room Service - Dinner	32.00	
	Room# 0916 : CHECK# 0030690		
09-15-10	Room Charge	149.	
09-15-10	Destination Marketing Fee	1.00	
09-15-10	Alberta Tourism Levy	5.00	
09-15-10	Room GST	7.00	
Room GST	15.04	Other PST 0.00	Other GST 0.00
		F&B Tax	25
Net Amount	331.73	CAD	
<b>Total</b>			<b>359.94</b>
<b>Balance</b>			<b>59.94</b>

11.92

Join goldpoints plus today! Enroll in goldpoints plus at a participating hotel front desk or on [goldpointsplus.com](http://goldpointsplus.com) and start earning Gold Points today!

**Thank You For Staying With Us**

I agree that my liability for this bill is not waived and agree to be held personally responsible in the event that the indicated person, company or association fails to pay for any portion or the full amount of these charges.

GST# 865627822

Guest Signature \_\_\_\_\_

Radisson Hotel Calgary  
 2120 16th Avenue NE  
 Calgary, AB T2E 1B9  
 Telephone: (403) 291-4666 Fax: (403) 291-6498



Travel & Employee Expense Claim Form

RECEIVED  
MAY 24 2011  
MAJOR TERTIARY HOSPITALS

s.17(1), 17(4)(g)(i)

Out-of-Province Travel: <input type="checkbox"/>	Prior Approval Date (related to Out-of-Province only):	Prior Approved by (related to Out-of-Province only):
Name: Glenda Coleman-Miller	Employee #:	Union Name: n/a
Position (Title): Vice President	Department: UAH Site Administration	Location: UAH
Business Phone #: 407-8009	Travel Period From: Dec 2010 to May 2011	

Expenses Paid (please attach original receipts and retain a copy for your records). Do not include amounts paid by Alberta Health Services or reimbursed / reimbursable by another organization. Complete details on page 2 of the form.

Summary of Travel & Employee Expenses (by Expense Account)						
Finance Code / Accounting Distribution				Non-Canadian Currency	Exchange Rate	Canadian \$
Balancing Unit	Location	Functional Centre	Expense/Secondary Account			
101	0300	71110100064	61540000			\$478.87
			623120000			
Alberta Health Services Accounts Payable JUN 01 2011 RECEIVED						
Subtotal						
Less Cash Advance (if applicable)						
Total						\$478.87 ✓

I hereby certify that the expenses listed above are in accordance to applicable policies and were incurred on Alberta Health Services business and have not been previously claimed by me or on my behalf from Alberta Health Services or other organization.

Employee Signature: Glenda Coleman-Miller Date: 2011-05-20

I hereby certify that I have reviewed the expenses and that they are in accordance with the applicable policies.

Approved By (please print): Deb Gordon	Title: SVP	Phone # 407-2761/943-1481
Signature: <u>Deb Gordon</u>		Date: <u>May 26/11</u>
Approved By (please print):	Title:	Phone #
Signature:		Date:

NOTE: Expense claim must be properly authorized in accordance with Alberta Health Services Policies (i.e. Travel expense in accordance with Travel Policy, etc.) and must be supported by original receipts or a copy as certified by the approver. See page 2 of this form for Travel expense claim limits. Approved claim form with receipts should be sent to Accounts Payable for processing.



APPLICANT COPY



**DELTA**

CALGARY SOUTH

135 Southland Drive S.E. Calgary, Alberta, T2J 5X5

Tel: 403-278-5050 Fax: 403-225-5834

**ALBERTA HEALTH SERVICES**

Glenda Coleman-Miller  
 University of Alberta Hospital  
 Edmonton, AB T6G 2B7  
 CA

Room: 0281  
 Folio:  
 Cashier: 122  
 Arrival: 05-03-11  
 Departure: 05-05-11

Group: AHS Provincial Senior Leadership Meeting

Date	Description	Additional Information	Charges	Credits
05-03-11	Room Charge		159.00	
05-03-11	DMF		4.77	
05-03-11	Room GST		8.19	
05-03-11	Tourism Levy		6.55	
05-04-11	In Room Dining Charges	#281 : CHECK #0050	19.85	
05-04-11	Room Charge		159.00	
05-04-11	DMF		4.77	
05-04-11	Room GST		8.19	
05-04-11	Tourism Levy		6.55	

<b>GST Summary</b>	
Registration No:	895126332
Room	16.38
F&B	0.00
Other	0.00
<b>Total</b>	<b>16.38</b>

<b>Total</b>	<b>376.87</b>	<b>0.00</b>
<b>Balance Due</b>	<b>376.87</b>	<b>CDN</b>

Guest Signature: \_\_\_\_\_

I agree that my liability for this bill is not waived and I agree to be held personally liable in the event that the indicated person, company, or association fails to pay for any part of or the full amount of these charges.

I have accepted delivery of the Globe and Mail. If refused, a \$1.00 (Mon-Fri) and \$2.00 (Sat) credit will be applied to my account.



APPLICANT COPY

Managed by ADVANCED PARKING STATION:PO# Pedway 2

Paid On:2011/05/06 12:54

Entered:2011/05/06 11:31  
Ticket#:0044395933  
Dur.:82:44

Paid:\$ 7.50  
Original Fee:\$ 7.50  
Dur.:82:44  
Fee:1  
Change:\$ 0.00

Credit Card:VISA 4528 1131  
SC:\$ 0.00

Thank-You...Come Again  
s.17(1), 17(4)(e.1)

GST#12201 4491 R10003  
Swiped

VISA  
Purchase 11/05/06 12:54:33  
Seq# 0010015370 66153525  
Auth# 029639  
01/02? APPROVED - THANK YOU

Compass Restaurant  
2001 Airport Rd N.E  
Calgary, Alberta T2E 6Z8  
(403) 291-2600  
CHECK: 1807  
TABLE: 30 / 1  
SERVER: 104 Ivy  
DATE: MAY03'11 11:45AM  
CARD TYPE: VISA  
ACCT #:  
EXP DATE: 00/00  
AUTH CODE: 025369  
GLENDIA COLEMAN-MILLER

s.17(1), 17(4)(e.1)

SUBTOTAL: 16.80  
GRATUITY 3.20  
TOTAL 20.00  
SIGNATURE *bcw*

PLEASE RETURN A SIGNED COPY  
TO YOUR SERVER  
GST #846543619

Welcome To Edmonton  
City Centre East Parkade

Managed by ADVANCED PARKING STATION:PO# Pedway 2

Paid On:2011/05/06 13:04

Entered:2011/05/06 10:11  
Ticket#:0044391123  
Dur.:171:58

Paid:\$ 14.00  
Original Fee:\$ 14.00  
Dur.:171:58  
Fee:1  
Change:\$ 0.00

Credit Card:VISA 4514 6882  
SC:\$ 0.00

Thank-You...Come Again  
s.17(1), 17(4)(e.1)

GST#12201 4491 R10003  
Swiped

VISA  
Purchase 11/05/06 13:09:51  
Seq# 0010015400 66153525  
Auth# 004949  
01/02? APPROVED - THANK YOU

AMOUNT PAID

\$ 13.00

84880000

08:16 AM

EXPIRATION DATE  
01/12/10

EXPIRATION TIME  
11:31 AM

DATE ISSUED  
01/12/10

TIME ISSUED  
08:16 AM

AMOUNT PAID  
\$ 13.00

CREDIT CARD NUMBER

LOT N

DISPLAY THIS SIDE UP ON DASHBOARD

DETACH RECEIPT FROM TICKET

PRESTIGE  
CABS

780-462-4444

GST# \_\_\_\_\_

Date: 03-May 11 Amount: 55.

Driver: Q Car #: \_\_\_\_\_

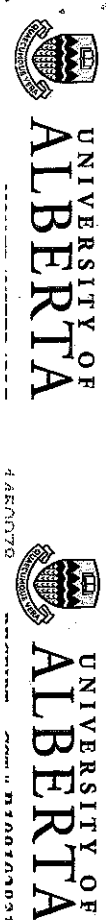
s.17(1), 17(4)(g)(i)

From: \_\_\_\_\_

To: IAP



10135 - 31 Avenue, Edmonton, AB T6N 1C2



APPLICANT COPY



Travel & Employee Expense Claim Form *A/P: May 6/11*  
s.17(1), 17(4)(g)(i)

Out-of-Province Travel: <input type="checkbox"/>	Prior Approval Date (related to Out-of-Province only):	Prior Approved by (related to Out-of-Province only):
Name: Glenda Coleman-Miller	Employee #:	Union Name:
Position (Title): VP - UAH/Stollery & MAHI	Department: Site Administration	Location: WMC 1F1
Business Phone #: 780-407-8726	Travel Period From: April 8 to April 10, 2011	
What former entity payroll system is the employee being paid from? (please <input checked="" type="checkbox"/> one from below)		
<input type="checkbox"/> AADAC	<input type="checkbox"/> Calgary Health	<input type="checkbox"/> East Central
<input type="checkbox"/> Alberta Cancer Board	<input checked="" type="checkbox"/> Capital Health	<input type="checkbox"/> Northern Lights
<input type="checkbox"/> Alberta Mental Health Board	<input type="checkbox"/> Chinook	<input type="checkbox"/> Palliser Health
<input type="checkbox"/> Aspen	<input type="checkbox"/> David Thompson	<input type="checkbox"/> Peace Country

Expenses Paid (please attach original receipts and retain a copy for your records). Do not include amounts paid by Alberta Health Services or reimbursed / reimbursable by another organization. Complete details on page 2 of the form.

Summary of Travel & Employee Expenses (by Expense Account)						
Finance Code / Accounting Distribution (if applicable)				Non-Canadian Currency	Exchange Rate	Canadian \$
Corp/BU/Org (if applicable)	Location (if applicable)	Functional Centre/Primary	Expense/Secondary Account			
103	0300	71210402016	62312000			\$529.65
Alberta Health Services Accounts Payable JUN 29 2011				Alberta Health Services Accounts Payable MAY 10 2011 RECEIVED		
Total GST						
Subtotal						529.65
Less Cash Advance (if applicable)						
Total						\$529.65

I hereby certify that the expenses listed above are in accordance to applicable policies and were incurred on Alberta Health Services business and have not been previously claimed by me or on my behalf from Alberta Health Services or other organization.

Employee Signature: *Glenda Coleman-Miller* Date: *Apr. 27/11*

I hereby certify that I have reviewed the expenses and that they are in accordance with the applicable policies.

Approved By (please print): Christine Westerlund	Title: Site Director, Stollery	Phone # 780-407-6035
Signature: <i>[Signature]</i>		Date: <i>Apr 11 2011</i>
Approved By (please print): <i>Deborah SV</i>	Title:	Phone # <i>407-2761</i>
Signature: <i>[Signature]</i>		Date:

NOTE: Expense claim must be properly authorized in accordance with Alberta Health Services Policies (i.e. Travel expense in accordance with Travel Policy, etc.) and must be supported by original receipts or a copy as certified by the approver.

**Travel & Employee Expense Claim Form** *A/P: May 6/11*  
 s.17(1), 17(4)(g)(i)

<b>Out-of-Province Travel:</b> <input type="checkbox"/>	<b>Prior Approval Date</b> (related to Out-of-Province only):	<b>Prior Approved by</b> (related to Out-of-Province only):
<b>Name:</b> Glenda Coleman-Miller	<b>Employee #:</b>	<b>Union Name:</b>
<b>Position (Title):</b> VP - UAH/Stollery & MAHI	<b>Department:</b> Site Administration	<b>Location:</b> WMC 1F1
<b>Business Phone #:</b> 780-407-8726	<b>Travel Period From:</b> April 8 to April 10, 2011	
<b>What former entity payroll system is the employee being paid from? (please <input checked="" type="checkbox"/> one from below)</b>		
<input type="checkbox"/> AADAC	<input type="checkbox"/> Calgary Health	<input type="checkbox"/> East Central
<input type="checkbox"/> Alberta Cancer Board	<input checked="" type="checkbox"/> Capital Health	<input type="checkbox"/> Northern Lights
<input type="checkbox"/> Alberta Mental Health Board	<input type="checkbox"/> Chinook	<input type="checkbox"/> Palliser Health
<input type="checkbox"/> Aspen	<input type="checkbox"/> David Thompson	<input type="checkbox"/> Peace Country

Expenses Paid (please attach original receipts and retain a copy for your records). Do not include amounts paid by Alberta Health Services or reimbursed / reimbursable by another organization. Complete details on page 2 of the form.

Summary of Travel & Employee Expenses (by Expense Account)						
Finance Code / Accounting Distribution (if applicable)				Non-Canadian Currency	Exchange Rate	Canadian \$
Corp/BU/Org (if applicable)	Location (if applicable)	Functional Centre/Primary	Expense/Secondary Account			
103	0300	71210402016	62312000			\$529.65
Total GST						
Subtotal						529.65
Less Cash Advance (if applicable)						
Total						\$529.65

Alberta Health Services  
 Accounts Payable  
 MAY 10 2011  
 RECEIVED

I hereby certify that the expenses listed above are in accordance to applicable policies and were incurred on Alberta Health Services business and have not been previously claimed by me or on my behalf from Alberta Health Services or other organization.

Employee Signature: *Christine Westlund for Glenda Coleman-Miller* Date: *Apr. 27/11*

I hereby certify that I have reviewed the expenses and that they are in accordance with the applicable policies.

<b>Approved By</b> (please print): Christine Westlund	<b>Title:</b> Site Director, Stollery	<b>Phone #</b> 780-407-6035
<b>Signature:</b> <i>[Signature]</i>		<b>Date:</b> <i>Apr 11, 2011</i>
<b>Approved By</b> (please print):	<b>Title:</b>	<b>Phone #</b>
<b>Signature:</b>		<b>Date:</b>

NOTE: Expense claim must be properly authorized in accordance with Alberta Health Services Policies (i.e. Travel expense in accordance with Travel Policy, etc.) and must be supported by original receipts or a copy as certified by the approver.

**EXPENSE CLAIM DETAILS**

Date (DD/MM/YY)	Particulars (Describe Purpose of Trip & Location)	GST \$	Accommodation \$	Meal Type B, L or D	Meals \$	Course Registration & Material \$	Transportation \$	Other \$	Mileage km
	<i>Expenses Outlined on attached sheet.</i>								
<b>Total KM</b>									
<b>Applicable Mileage rate @</b>									
<b>Totals</b>									

Note: Record the total amount for each expense categories from above to the summary table on page 1

APPLICANT COPY

**EXPENSE LIMITS - (Summary information only. Please refer to AHS Travel Policy for terms and conditions.) (Except where collective agreement specifies otherwise).**

1. **Meal Expenses and Allowances**  
Meal allowances is the actual cost of the meal as shown on the receipt, excluding alcoholic beverages, including up to 15% gratuity, and GST, to a maximum as prescribed below. At discretion of the signing officer, the below maximum meal expense shall also apply where no receipt is available.
  - a) Breakfast = B \$10
  - b) Lunch = L \$12
  - c) Dinner = D \$21
 Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the meeting.
  
2. **Accommodation Expense and Allowances**  
Accommodation expense claims may be made at the actual cost of the room and applicable taxes. The claim is expected to be reasonable given the location and availability of government rates. Accommodation allowance without a receipt is \$20 per night.
  
3. **Travel**
  - Use of personal automobile - Reimbursement at the general rate of \$0.505 per km for approved travel in a fiscal year.
  - Vehicle owners are responsible for any losses that may arise.
  - Business car insurance is reimbursable up to \$500 per year with receipts.
  - Includes all forms of transportation costs, including taxis, air plane and buses for travel related to AHS.
  - Driving from home to a designated work location, and returning home from a designated work location, is not considered business travel and cannot be claimed.
  
4. **Advance**  
Travel advance may be requested provided travel expenses are likely to exceed \$500.



APPLICANT COPY



405 SPRAY AVENUE  
P.O. BOX 960  
BANFF, ALBERTA CANADA T1L 1J4  
T 403 762 2211 F 403 762 5755  
G.S.T. Registration # 84968 1721 RT0006

Room : 0623  
Folio # : 704872  
Cashier # : 947  
Page # : 1 of 1

Group Name : Western Canadian Children's Heart N

Western Canadian Children's Heart Network  
MS Glenda Coleman-Miller

s.17(1), 17(4)(g)(i)

Arrival : 04-08-11  
Departure : 04-10-11

Fairmont President's Club  
s.17(1), 17(4)(g)(i)

INFORMATION INVOICE

Date	Description	Additional Information	Charges	Credits
04-08-11	Valet Parking		33.00 ✓	
04-09-11			Non-Responsive 20.95	
04-09-11	Valet Parking		33.00 ✓	
04-10-11	In Room Dining	Line# 623 : CHECK# 0022039	17.83 ✓	
04-10-11	Visa			104.78
04-12-11	Package Gratuity Inclusion	\$10 Service charge per adult/night	20.00	
04-12-11	Package GST (5%)		1.00	
04-12-11	Visa			21.00
<b>Total</b>			<b>125.78</b>	<b>125.78</b>
<b>Balance Due</b>				<b>0.00</b>

GST Summary

Room	0.00
F&B	0.85
Other	5.14
<b>Total</b>	<b>5.99</b>

For information or reservations, visit us at  
[www.fairmont.com](http://www.fairmont.com) or call Fairmont Hotels & Resorts from:  
United States or Canada 1 800 441 1414  
Pour information et réservations visitez notre web au  
[www.fairmont.com](http://www.fairmont.com) ou téléphoner au Hôtels Fairmont de:  
États-Unis ou Canada 1 800 441 1414

I agree that my liability for this bill is not waived and I agree to be held personally liable in the event that the indicated person, company or association fails to pay for any part of or the full amount of these charges. Overdue balance subject to a surcharge at the rate of 1.5% per month after one month. (18.00% per annum.)  
I have accepted delivery of The Globe and Mail. Had I refused, I would have been eligible for a \$1.00 (Mon-Fri) and \$2.00 (Sat.) credit to my account. (At participating hotels.)

Je me porte personnellement responsable du règlement total de cette note au cas où la compagnie, l'association ou son représentant désigné en refuserait le paiement. Les comptes en souffrance sont sujets à un intérêt de 1.5% par mois après un mois. (18.00% par année)  
J'ai accepté la livraison du journal The Globe and Mail. Si j'avais refusé, j'aurais pu obtenir un crédit à mon compte de 1.00\$ par jour (du Lundi au Vendredi) et de 2.00\$ le Samedi (Dans les hôtels participants.)

Thank you for choosing to stay with Fairmont Hotels & Resorts  
Merci d'avoir choisi les Hôtels Fairmont

APPLICANT COPY

**Denise Gagne**

---

**From:** Denise Gagne  
**Sent:** Thursday, June 09, 2011 1:59 PM  
**To:** Deidre Rainey  
**Cc:** Glenda Coleman-Miller  
**Subject:** Re: Coleman-Miller Exp - 529.65

**Importance:** High

**Attachments:** Coleman-Miller.pdf

Hello,

You have submitted an expense claim that requires a higher level approval signature. Please have an SVP or higher level sign for approval.

Please scan an email back to me as I have original receipts.



Coleman-Miller.pdf  
(958 KB)

Thanks

**Denise Gagné**

***Accounts Payable***

**Alberta Health Services**

**10th Flr, North Tower**

**10030-107 Street**

**Edmonton, AB T5J 3E4**

**Ph: 780-735-0464**

**Fax: 780-735-0508**

**Email: [denise.gagne@albertahealthservices.ca](mailto:denise.gagne@albertahealthservices.ca)**

This communication is intended for the use of the recipient to which it is addressed, and may contain confidential, personal, and or privileged information. Please contact us immediately if you are not the intended recipient of this communication, and do not copy, distribute, or take action relying on it. Any communication received in error, or subsequent reply, should be deleted or destroyed.

Apr 21

Hi Diana

Expenses for  
Glenda

Not sure if her  
breakfast is covered  
on the 10<sup>th</sup> but have  
included just in case.

Please advise about  
kilometer re-imbursment  
is it at 0.50 per km?

If so please add

844 km @ .505

~~\$422.00~~ \$426.00

Glenda's address is  
on the attached  
invoice from the  
Banff Springs.

JH  
Fulmer

Fairmont Banff Springs  
In Room Dining

2531 Meghan

523/1      CHK 2039   GST 1  
COLEMAN-MILLER  
APR10'11 10:18AM

1 Delivery Charge	4.00
1 Egg	6.00
1 Toast	5.00
Food	11.00
Delivery Charge	4.00
IRD AUTO GRAT	1.98
GST	0.85
Total Due ..	\$17.83

PARC NATIONAL  
BANFF  
NATIONAL PARK

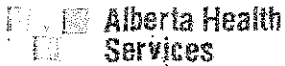
04/08/2011

Valid/Valide - 16h:  
/10/2011

9.80	
:AD IND/JR:1 ADULTE	19.60
total	19.60
/TPS	0.93
n/Comptant	19.60
2 PM F.B.	791
E/BARRIERE-BANFF3	



# APPLICANT COPY



## Travel & Employee Expense Claim Form

(In Canadian Dollars)

s.17(1), 17(4)(g)(i)

Name: Glenda Coleman-Miller	Employee Number: <i>CHP</i>	Union Name:
Position: Vice President	Department: Administration	
Business Phone: 780-407-8009	Period From: May/11	to Jun/11

Expenses Paid (please attach receipts). Do not include amounts paid by Alberta Health Services or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST Included
101	0300	71110100064	62310000			\$62.75	<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
<b>Total</b>						<b>\$62.75</b>	<input type="checkbox"/>

Alberta Health Services  
Accounts Payable  
AUG 16 2011  
RECEIVED

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Alberta Health Services business and have not been previously claimed by me or on my behalf from Alberta Health Services or other organization.

Employee Signature: *Glenda Coleman-Miller*

Date: *2011-08-05*

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: Mike Conroy <small>(Print name)</small>	Title: Acting SVP, Edmonton Zone	Phone # <i>342-2016</i>
<small>(Signature)</small>		Date <i>Aug 12/11</i>
Approved By:	Title:	Phone #
<small>(Print name)</small>		
<small>(Signature)</small>		Date

**NOTE:**

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
- GST amounts included in the expense claims will be calculated by Accounts Payable.
- Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
- For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
- For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
- See page 2 of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

# APPLICANT COPY EXPENSE CLAIM DETAILS

## Recommended Coding

- 61530030 – Workshop Fees & Materials
- 61520020 – Academic Course Fees & Materials
- 61540040 – Conference Fees & Materials
- 62300000 – Meals
- 62320000 – Staff Local Travel – Client Related
- 62310000 – Staff Local Travel – Non-Client Related
- 62320000 – Staff Local Travel – Taxi – Client Related
- 62310000 – Staff Local Travel – Taxi – Non-Client Related
- 62320000 – Staff Travel – UNA – Client Related
- 62310000 – Staff Travel – UNA – Non-Client Related
- 62312000 – Staff Provincial Travel – Non-Client Related
- 62314000 – Staff Out of Province Travel – Non-Client Related
- Catering – 69600000

Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
May 25/11	Parking				\$5.00		
May 26/11	Parking				8.00		
Jun 7/11	Parking				25.00		
Jun 7/11	Meal		15.75				
Jun 30/11	Parking				9.00		
<b>Total km</b>							
<b>Rate as outlined in Section 2 – Travel below @</b>							
<b>Totals</b>			\$15.75		\$47.00		

### EXPENSE LIMITS

#### 1. Meal Allowances

When traveling on Alberta Health Services business, the employee may be reimbursed at the Per Diem meal allowance of:

- Breakfast \$10.00 (if the departure time is earlier or the return time is later than 7:30 a.m.)
- Lunch \$15.00 (if the departure time is earlier or the return time is later than 1:00 p.m.)
- Dinner \$25.00 (if the departure time is earlier or the return time is later than 6:30 p.m.)

For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.

Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.

#### 2. Travel

- Use of personal automobile – From August 1, 2008, reimbursement at the general rate of \$0.505 per km for approved travel in a fiscal year [April 1 to March 31] (except where collective agreement specifies otherwise).
- Business car insurance is reimbursable up to \$500 per year with receipts in accordance with Alberta Health Services Policy.
- Effective August 1, 2008, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
  1. Monthly travel in excess of 340 kilometers; or
  2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
  3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.52 per kilometer.
- If union contract rate differs from \$0.505 then contract rate must be used.
- Includes all forms of transportation costs, including taxis and buses for local travel.
- Driving to and from work is not considered business travel and cannot be claimed.

#### 3. Advance

Travel advance may be requested provided travel expenses are likely to exceed \$500.



Compass Restaurant  
 (403) 291-2600

103 Katrina

30/1 2543 GST 1  
 JUN07'11 8:05AM

1 Trad Omelette 12.00  
 1 Coffee 3.00  
 FOOD 15.00  
 GST 0.75  
 8:20 Total Due \$ 15.75

GRATUITY \_\_\_\_\_

TOTAL \_\_\_\_\_

ROOM NUMBER \_\_\_\_\_

PRINT NAME \_\_\_\_\_

SIGNATURE \_\_\_\_\_

PLEASE PAY YOUR SERVER  
 GST #846543619

EXPIRATION DATE 25/05/11 EXPIRATION TIME 09:01 AM DATE ISSUED 25/05/11 TIME ISSUED 08:01 AM AMOUNT PAID \$ 5.00

\* AMOUNT PAID \$ 5.00 84950000 08:01 AM



UNIVERSITY OF ALBERTA

0605544

NON TRANSFERABLE

CREDIT CARD NUMBER LOT PhysEd-N/HOURLY



UNIVERSITY OF ALBERTA

0605544

RECEIPT GST # R1081028

*B&Q meeting May 26 2:00pm*

EXPIRATION DATE 26/05/11 EXPIRATION TIME 12:02 PM DATE ISSUED 26/05/11 TIME ISSUED 10:02 AM AMOUNT PAID \$ 8.00

AMOUNT PAID \$ 8.00 84800000 10:02 AM



UNIVERSITY OF ALBERTA

0627998

NON TRANSFERABLE

CREDIT CARD NUMBER LOT M



UNIVERSITY OF ALBERTA

0627998

RECEIPT GST # R108102

07/06/11 06:11 -  
 07/06/11 21:43 -  
 Period 0d15h33'  
 (Tax) \$25.00  
 Total \$25.00  
 Payment Received \$25.00  
 Cash  
 Sub Total \$23.81  
 Tax 5% 1.19  
 Amount Paid \$30.00  
 Change \$5.00

*Just & Trusting  
 Leadership Advisory mtg  
 in Calgary*  
 GST # R128599776  
 Edmonton Airports  
 Can-T5J 2T2 Edmonton  
 Tax CodeCA5%

Purchase Date/Time: 02:55pm Jun 30, 2011  
 Total Parking: \$8.57  
 Total gst: \$0.43  
 Total Due: \$9.00  
 Total Paid: \$9.00  
 # Visa  
 Ticket #: 30072602  
 SIN #: 100008440038  
 Setting: Lot 256  
 Mach Name: Meter 1  
 GST #667316638R10001  
 s.17(1), 17(4)(e.1)  
**RECEIPT**  
 Impark Lot 256

Expiration Date/Time: 04:25pm Jun 30, 2011  
 Purchase Date/Time: 02:55pm Jun 30, 2011  
 Total Parking: \$8.57  
 Total gst: \$0.43  
 Total Due: \$9.00  
 Total Paid: \$9.00  
 Visa  
 Ticket #: 30072602  
 Setting: Lot 256  
 Mach Name: Meter 1  
 Rate: \$9 - 15 Hour  
 Payment Type: Card  
 Auth #: 067334

**PLACE FACE UP ON DASH**  
 Impark Lot 256  
 Expiration Date/Time  
**EXP 04:25PM**  
**JUN 30, 2011**

*M Conroy 11:10*  
**PLACE FACE UP ON DASH**  
 Impark Lot 256  
 Expiration Date/Time  
**EXP 04:25PM**  
**JUN 30, 2011**

Purchase Date/Time: 02:55pm Jun 30, 2011  
 Total Parking: \$8.57  
 Total gst: \$0.43  
 Total Due: \$9.00  
 Total Paid: \$9.00  
 Rate: \$9 - 1.5 Hours  
 Payment Type: Card  
 Visa  
 Ticket #: 30072602  
 S/N #: 100008440036  
 Setting: Lot 256  
 Mach Name: Meter 1  
 GST #887315638RT0001  
 s.17(1), 17(4)(e.1)

**RECEIPT**  
 Impark Lot 256

Expiration Date/Time: 04:25pm Jun 30, 2011  
 Purchase Date/Time: 02:55pm Jun 30, 2011

Total Parking: \$8.57  
 Total gst: \$0.43  
 Total Due: \$9.00  
 Total Paid: \$9.00  
 Rate: \$9 - 1.5 Hours  
 Payment Type: Card  
 Visa  
 Ticket #: 30072602  
 Setting: Lot 256  
 Mach Name: Meter 1  
 Auth #: 067334

PARKING RECEIPT

EXPIRATION DATE: 25/05/11 09:01 AM  
 EXPIRATION TIME: 08:01 AM  
 AMOUNT PAID: \$ 5.00  
 CREDIT CARD NUMBER: 84950000  
 UNIVERSITY OF ALBERTA  
 0605544  
 NON TRANSFERABLE  
 084 Meeting May 26 Lister Hall

DATE ISSUED: 25/05/11  
 TIME ISSUED: 08:01 AM  
 AMOUNT PAID: \$ 5.00  
 CREDIT CARD NUMBER: LOT PhysEd-V/HOURLY  
 UNIVERSITY OF ALBERTA  
 0605544  
 RECEIPT GST#R108102  
 DETACH RECEIPT FROM TICKET

EXPIRATION DATE: 26/05/11 12:02 PM  
 EXPIRATION TIME: 10:02 AM  
 AMOUNT PAID: \$ 8.00  
 CREDIT CARD NUMBER: 84880000  
 UNIVERSITY OF ALBERTA  
 0627998  
 NON TRANSFERABLE

DATE ISSUED: 26/05/11  
 TIME ISSUED: 10:02 AM  
 AMOUNT PAID: \$ 8.00  
 CREDIT CARD NUMBER: LOT M  
 UNIVERSITY OF ALBERTA  
 0627998  
 RECEIPT GST#R108102  
 DETACH RECEIPT FROM TICKET

07/06/11 06:11	- s.17(1), 17(4)(g)(i)	
07/06/11 21:43	Period 0d15h33'	
(Tax)		\$25.00
Total		\$25.00
Payment Received		\$25.00
Cash		\$25.00
Sub Total		\$23.81
Tax 5%		1.19
Amount Paid		\$30.00
Change		\$5.00

Short-term parking tkt  
 Exit #1 Ca 07/06/11 21:43  
 Cashier 38  
 Receipt 023011  
 Can-15J 212 Edmonton  
 Tax CodeCASX  
 Edmonton Airports  
 GST # R128599776  
 in Calgary

30/1 2543 GST 1  
 JUN07'11 8:05AM  
 1 Trad Omelette 12.00  
 1 Coffee 3.00  
 FOOD 15.00  
 GST 0.75  
 8:20 Total Due \$15.75  
 GRATUITY  
 TOTAL 204  
 ROOM NUMBER  
 PRINT NAME  
 SIGNATURE  
 PLEASE PAY YOUR SERVER  
 GST #846543619

Compass Restaurant  
 (403) 291-2600  
 103 Katrina  
 DELTA  
 CALGARY AIRPORT

# APPLICANT COPY

**Alberta Health Services**

## TRAVEL, HOSPITALITY & HOSTING EXPENSE CLAIM FORM

PLEASE DO NOT USE ENTER KEY TO NAVIGATE THIS FORM → USE TAB, ARROW KEYS OR MOUSE

<b>SECTION A – Employee Details (for AHS Staff ONLY)</b>							
→ Enter Employee # (old) and Employee # (E-People) if you have migrated to the New E-People payroll system. → Indicate N/A in the Employee # (E-People) if you have not migrated to the New E-People payroll system. → If you are a new employee and payroll has migrated to E-People you will only have an Employee # (E-People).							
Employee # (old)		Employee # (E-People)		Name: Glenda Coleman-Miller			
Position (Title): V17(4)(g)(i)		Location: UAH		Dept: Site Admin		Out-of-Province Travel: <input type="checkbox"/>	
Union Name:		Business Phone #: 407-8009		Travel Period from: to			
What former entity payroll system is the employees currently being paid from? (Please ✓ one from below)							
<input type="checkbox"/> AADAC		<input type="checkbox"/> Calgary Health		<input type="checkbox"/> East Central			
<input type="checkbox"/> Alberta Cancer Board		<input checked="" type="checkbox"/> Capital Health		<input type="checkbox"/> Northern Lights			
<input type="checkbox"/> Alberta Mental Health Board		<input type="checkbox"/> Chinook		<input type="checkbox"/> Palliser Health			
<input type="checkbox"/> Aspen		<input type="checkbox"/> David Thompson		<input type="checkbox"/> Peace Country			
<b>SECTION B – Finance Coding &amp; Total Claim – Complete separate Page 2 for each Functional Centre</b>							
Finance Code / Accounting Distribution → Expense Object Code (EOC)/secondary code not required in this section							
Bal Unit (3 char)	Location (4 char)	Functional Centre (FC) (11 char)	pg	Travel \$s	pg	Other \$s	Total
101	0300	71110100064	2A	\$2,656.62	3	\$504.00	\$3,160.62
			2B		3		
			2C		3		
			2D		3		
				Converted Foreign Currency \$s			
				Less Cash Advance if applicable			
→ Claim should include a minimum of 2 pages + receipts						<b>TOTAL CLAIM</b>	
						\$3,160.62	

Alberta Health Services  
 Accounts Payable  
 NOV 02 2011

**IMPORTANT NOTE → Applicable to all Sections A to F**

If this form is not filled in correctly, legibly and completely, the form will be returned.  
 In order to facilitate processing of this claim, please review the following notes –

- Email approvals, physical signature stamp or similar device are not acceptable
- Employee # refers to the number indicated on employee's pay stub
- Out-of-Province Travel – the approver **MUST** ensure all documentation and approval levels are compliant as per the Travel Policy **BEFORE** submission to Accounts Payable

①

<b>SECTION F - Authorization</b>			
If applicable, <u>print</u> 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 approval signatures required as well as DOFA level (delegation of authority level) and Position # of the approver.			
Claim Prepared by (PRINT ONLY) Deidre Rainey		Phone # 407-8009	
I hereby certify that the expenses listed above are in accordance to applicable policies and was incurred on Alberta Health Services business and have not been previously claimed by me or on my behalf from Alberta Health Services or other organization.			
Employee Signature: <i>Glenda Coleman-Miller</i>		Date: 2011-10-27	
I hereby certify that I have reviewed the expenses and they are in accordance with the applicable policies (Policy #'s CF-03, CF-04). Approved claim form with receipts should be sent by the approver directly to Accounts Payable for processing.			
Approved By (PRINT ONLY) Mike Conroy	DOFA level	Position # SVP	Phone #
Signature:	Title: SVP, Edmonton Zone		Date:
Approved By (PRINT ONLY)	DOFA level	Position #	Phone #
Signature:	Title:		Date:

NOTE: Expense claims must be properly authorized and appropriately supported in accordance with Alberta Health Services Policies

AB

EXPENSE CLAIM DETAILS

<b>Enter Finance Coding as per page 1</b> →	<b>101. 0300.71110100064</b> bal unit (3 char), location (4 char), and functional centre (11 char)	<b>Page 2</b> (enter A, B or C as required) → <b>A</b>
---	---	---

**SECTION C Travel & Education Expenses**      **NOTE: If expenses do not fall into these categories, go to SECTION D**

Ensure separate lines are used for claim items that differ in province of expense. Enter total \$ amount on slip, **DO NOT** separate GST. Secondary/Expense codes are not required to be indicated in this section as they are pre-determined by the system.

Date (dd/mm/yy)	Purpose of Travel/Education	Prov of Exp (ie AB, BC, etc)	Hotel \$	Meals \$ (Type B, L, D or A for All)		Taxi \$	Transportation \$				Course Reg / Material \$	Mileage (km)
				Type	w/receipt		w/o receipt or per diem	Airfare	Bus	Parking		
05/05/11	Meeting Downtown					15.00						3.00
07/09/11	Meeting at RAH							9.00				6.00
16/09/11	Meeting at RAH							9.00				6.00
21/09/11	Meeting at RAH							17.00				6.00
18/10/11	Meeting at RAH							9.00				6.00
20/10/11	Meeting Downtown							6.75				3.00
20/10/11	Meeting at RAH							17.00				6.00
09/24/11	ACEN Conference	ON	400.02	A		35.77						
09/28/11	Travel from Airport to Hotel	AB				10.00						
09/28/11	Senior Leadership Meeting	AB	664.90									
09/24/11	ACEN Conference Registration									1445.00		
<b>(sum applicable columns) SUBTOTALS</b>						<b>0.00</b>						<b>36.00</b>
				<b>1064.92</b>		<b>25.00</b>	<b>0.00</b>	<b>0.00</b>	<b>67.75</b>	<b>0.00</b>	<b>1445.00</b>	<b>0.505</b>

**TRAVEL EXPENSE LIMITS** – (Refer to CF-04 for terms and conditions, except where collective agreement specifies otherwise)  
**Meal Expenses & Allowances**  
 Actual cost of the meal as shown on the receipt, excluding alcoholic beverages, including up to 15% gratuity and GST to a maximum (with or without receipt) as indicated below.  
 a) Breakfast → \$10    b) Lunch → \$12    c) Dinner → \$21

Enter \$0.505 OR rate per Union Agreement	Mileage \$ 18.18
Enter on page 1 TOTAL TRAVEL \$	Travel \$'s Subtotal 2638.44
Enter on page 1 TOTAL TRAVEL \$	2656.62

Please enter above total for each page 2 separately onto page 1, Section B

EXPENSE CLAIM DETAILS

SECTION D Other Expenses NOTE: If expenses are for travel or education (courses etc) go to SECTION C

ALL "OTHER" expenses listed below MUST have a secondary/expense code indicated
→ If no "Other" expenses are being claimed, this page does not have to be submitted.
→ Gas receipts & business insurance are claimed here in Section D - Other Expenses.

Subtotal "Other Expenses" for each functional centre separately and enter each subtotal on page 1



Table with columns: Date (dd/mm/yy), Purpose of Expense, Functional Centre (ie. 101.0767.71355000007), Secondary/Expense Code (ie: 4100000), A-GST on receipt, B-GST not on receipt, TOTAL Other \$\$

207

SECTION E Foreign Currency ONLY ENTER IN THIS SECTION IF AMOUNT NOT CONVERTED INTO CDN \$'S. All expenses will be paid in CDN \$'s and the exchange rate will be used from the Bank of Canada for the date of the expense. Accounts Payable will complete the currency exchange if not indicated on the receipt/document.

Table with columns: Date (dd/mm/yy), Purpose of Expense, Functional Centre (ie. 101.0767.71355000007), Secondary/Expense Code (ie: 4100000), Foreign Currency Amt (\$), For AP use ONLY (Exch Rate, CDN Value), Total Converted \$\$

Expenses Paid (Retain a copy for your records) Do not include amounts paid by Alberta Health Services or reimbursed / reimbursable by another organization.

# APPLICANT COPY

**Deidre Rainey**

---

**From:** Deidre Rainey on behalf of Glenda Coleman-Miller  
**Sent:** Wednesday, August 10, 2011 8:25 AM  
**To:** Deidre Rainey  
**Subject:** FW: ACHE Online Event Registration Confirmation

-----Original Message-----

**From:** [contact@ache.org](mailto:contact@ache.org) [<mailto:contact@ache.org>]  
**Sent:** Wednesday, August 10, 2011 8:01 AM  
**To:** Glenda Coleman-Miller  
**Cc:** [ERegistration@ache.org](mailto:ERegistration@ache.org)  
**Subject:** ACHE Online Event Registration Confirmation

Thank you for your registration!

**ID:** s.17(1), 17(4)(g)(i)  
**Order number:** 257455  
**Name:** Glenda Coleman-Miller  
**Meeting :** CAN2011

You have registered for the following:

**Title of seminar:** Coach, Challenge, Lead: Developing An Indispensable ...  
**Date:** September 26, 2011

**SubTotal:** \$1,445.00  
**Total charged** \$1,445.00

This e-mail serves as your receipt.

\*\*\*

You will also receive a final confirmation e-mail within 24 hours from ACHE's Customer Service Center. The final confirmation will include travel discount codes unique to ACHE attendees; therefore, if you are traveling to one of our seminars we recommend that you do not make travel arrangements until you receive the second confirmation. If the second e-mail is not successful, you will receive a letter mailed to the address listed on your registration form. If you have any questions regarding your registration, contact the ACHE's Customer Service Center at (312) 424-9400 or [contact@ache.org](mailto:contact@ache.org).

\*\*\*

This e-mail was sent from the American College of Healthcare Executives, 1 North Franklin Street, Suite 1700, Chicago, IL 60606-3424.





100 Front Street W  
 Toronto, ON, Canada M5J 1E3  
 T (416) 368-2511 F (416) 368-2884  
 G.S.T. Registration # 832522213

Mrs Glenda Coleman-Miller  
 10030 107th Street  
 Edmonton AB T5J 3E4  
 Canada

Room : 02299  
 Folio # :  
 Cashier # : 876  
 Page # : 1 of 2

Invoice No.  
 Arrival : 09-24-11  
 Departure : 09-27-11

Date	Description	Additional Information	Charges	Credits
09-24-11			165.00	
09-24-11			21.45	
09-24-11		Non-Responsive	50.00	
09-24-11			6.50	
09-25-11		Non-Responsive	36.14	
09-25-11			65.63	
09-25-11	Room Charge		165.00	
09-25-11	HST - Rooms		21.45	
09-25-11		Non-Responsive	50.00	
09-25-11			6.50	
09-26-11	In Room Dining	2299 : CHECK# 2314	35.77	
09-26-11	Room Charge		189.00	
09-26-11	HST - Rooms		24.57	
09-26-11			50.00	
09-26-11		Non-Responsive	6.50	
<b>Total</b>			<b>893.51</b>	<b>0.00</b>

Balance Due ~~893.51~~  
*expense claim* 435.79

<u>GST Summary</u>		<u>HST Summary</u>	
Room :	0.00	Room :	.97
F&B :	0.00	F&B :	.04
Other :	0.00	Other :	.00
<b>Total :</b>	<b>0.00</b>	<b>Total :</b>	<b>.01</b>

For information or reservations, visit us at  
[www.fairmont.com](http://www.fairmont.com) or call Fairmont Hotels & Resorts from:  
 United States or Canada 1 800 441 1414

I agree that my liability for this bill is not waived and I agree to be held personally liable in the event that the indicated person, company or association fails to pay for any part of or the full amount of these charges. Overdue balance subject to a surcharge at the rate of 1.5% per month after one month. (18.00% per annum.)  
 I have accepted delivery of The Globe and Mail. Had I refused, I would have been eligible for a \$1.00 (Mon-Fri) and \$2.00 (Sat.) credit to my account. (At participating hotels.)

APPLICANT COPY



100 Front Street W  
Toronto, ON, Canada M5J 1E3  
T (416) 368-2511 F (416) 368-2884  
G.S.T. Registration # 832522213

Mrs Glenda Coleman-Miller  
10030 107th Street  
Edmonton AB T5J 3E4  
Canada

Room : 02299  
Folio # :  
Cashier # : 876  
Page # : 2 of 2

Invoice No.  
Arrival : 09-24-11  
Departure : 09-27-11

Date	Description	Additional Information	Charges	Credits
------	-------------	------------------------	---------	---------

Thank you for choosing Fairmont Hotels & Resorts.  
To provide feedback about your stay please contact Heather McCrory, General Manager, at Heather.McCroryGM@Fairmont.com.  
We also invite you to share memories of your experience on our community forum - visit [www .everyonesanoriginal.com](http://www.everyonesanoriginal.com).

For information or reservations, visit us at  
[www.fairmont.com](http://www.fairmont.com) or call Fairmont Hotels & Resorts from :  
United States or Canada 1 800 441 1414

I agree that my liability for this bill is not waived and I agree to be held personally liable in the event that the indicated person, company or association fails to pay for any part of or the full amount of these charges. Overdue balance subject to a surcharge at the rate of 1.5% per month after one month. (18.00% per annum.)  
I have accepted delivery of The Globe and Mail. Had I refused, I would have been eligible for a \$1.00 (Mon-Fri) and \$2.00 (Sat.) credit to my account. (At participating hotels.)

Thank you for choosing to stay with Fairmont Hotels & Resorts



# Carriage House Inn

*Senior Leadership*

9030 Macleod Trail S., Calgary, Alberta, Canada T2H 0M4 Phone: (403) 253-1101 Fax: (403) 259-2414 Toll Free: 1-800-661-9566 www.carriagehouse.net

Guest:

Glenda Coleman-miller  
 Alberta Health Services  
 8440, 112th St.  
 Edmonton, AB T6G 2B7 CN

Room #: 1062  
 Folio #: R5AD19 - 1  
 Group #:  
 Guests: 1  
 Clerk:

CL #:

Arrive: 09/27/11 Time: 08:20 PM Depart: 09/29/11 Time: 05:06:39 Status: FOL

Date	Description	Reference	Comment	Charges	Credits
09/27/2011	ROOM CHARGE	1062		\$305.00	\$0.00
09/27/2011	ALBERTA MARKETING I	1062t	ALBERTA MARKETING LEVY	\$12.20	\$0.00
09/27/2011	ROOMS GST TAX	1062t	ROOMS GST TAX	\$15.25	\$0.00
09/28/2011				<del>\$16.00</del>	\$0.00
09/28/2011				<del>\$3.00</del>	\$0.00
09/28/2011				<del>\$0.80</del>	\$0.00
09/28/2011	ROOM CHARGE	1062		\$305.00	\$0.00
09/28/2011	ALBERTA MARKETING I	1062t	ALBERTA MARKETING LEVY <i>Non-Responsive</i>	\$12.20	\$0.00
09/28/2011	ROOMS GST TAX	1062t	ROOMS GST TAX	\$15.25	\$0.00

Folio Balance: ~~\$684.70~~

*Expense claim*  
 664.90

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

*"We Take Great Care of You"*

2% Per month is added to outstanding balance on overdue accounts.

Regardless of charge instructions, the undersigned guest acknowledges any charges incurred are a personal indebtedness. All accounts are due when rendered.

G.S.T. # R119507069

APPLICANT COPY

2012

Name: **Glenda Daisy Coleman-Miller**  
 Number: s.17(1), 17(4)(g)(i)  
 Date Issued: **25-Oct-2011**

Item	Amount
Registered Nurse (Renew) Fee	\$480.00
GST	\$24.00
Total	\$504.00

College & Association of Registered Nurses of Alberta  
 11620 – 168 Street, Edmonton, AB T5M 4A6  
 Telephone 780.451.0043 Fax 780.452.3276  
 Toll Free in Canada 1.800.252.9392  
 GST Reg. No. R106692643

OFFICIAL RECEIPT FOR INCOME TAX PURPOSES

*Issued pursuant to the Health Professions Act s. 40(2)*



11620 – 168 Street,  
 Edmonton, AB T5M 4A6  
 Telephone 780.451.0043  
 Fax 780.452.3276  
 Toll Free in Canada 1.800.252.9392

**2012 PRACTICE PERMIT**

Name: **Glenda Daisy Coleman-Miller**  
 Number: s.17(1), 17(4)(g)(i)  
 Type: **Registered Nurse**  
 Effective Date: **01-Oct-2011**  
 Expiry Date: **30-Sep-2012**  
 Conditions:

**Nursing Profession Act discipline conditions, if any, do not appear on this permit.**

This information was obtained from the Member Profile section of the College and Association of Registered Nurses of Alberta website  
[www.nurses.ab.ca](http://www.nurses.ab.ca) on 10/25/2011 at 09:18:36 AM MST.

This information should be considered current as of the date and time shown, and is subject to change. CARNA makes every effort to ensure that all of the information displayed is accurate; however, in the event of a discrepancy between the information displayed on this document and that provided by the Registrar, the Registrar will be deemed to be correct.

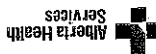
APPLICANT COPY

ST#: \_\_\_\_\_  
Date: 5/5/11  
Driver: \_\_\_\_\_  
Car #: 648  
From: 8400 - 11852  
To: 10030/107 ST

780-462-3456

**YELLOW CAB**

RECEIPT  
Alberta Health Services



1969422

Alberta Health Services  
1969422  
ALBERTA HEALTH SERVICES  
CHARGES ARE FOR USE OF PARKING SPACE ONLY. ALBERTA  
HEALTH SERVICES ENDORSERS TO PROTECT THE PROPERTY  
OF ITS PATRONS BUT WILL NOT BE RESPONSIBLE FOR LOSS  
OR DAMAGE TO CAR OR CONTENTS.  
NON TRANSFERABLE

\$ 9.00 76420000 06:40 PM

AMOUNT PAID

CREDIT CARD NUMBER

07/09/11 06:40 PM \$ 9.00

07/09/11 08:40 PM

DATE ISSUED TIME ISSUED AMOUNT PAID  
DETACH RECEIPT FROM TICKET

EXPIRATION DATE EXPIRATION TIME  
LEAVE ON DASH - THIS SIDE UP

GCN

RAY

RECEIPT  
3765259



PRECISE PARKLINK  
CHARGES ARE FOR THE USE OF THE PARKING SPACE ONLY.  
WE WILL NOT BE RESPONSIBLE FOR LOSS OR DAMAGE  
TO CAR OR CONTENTS, HOWEVER CAUSED, INCLUDING  
THEFT OR COLLISION.  
NON TRANSFERABLE 3765259

\$ 9.00 85220000 01:02 PM

AMOUNT PAID

CREDIT CARD NUMBER

16/09/11 01:02 PM \$ 9.00

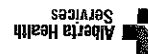
16/09/11 03:02 PM

DATE ISSUED TIME ISSUED AMOUNT PAID  
DETACH RECEIPT FROM TICKET

EXPIRATION DATE EXPIRATION TIME  
DISPLAY THIS SIDE UP ON DASHBOARD

RAY

RECEIPT  
Alberta Health Services



1970817

Alberta Health Services  
1970817  
ALBERTA HEALTH SERVICES  
CHARGES ARE FOR USE OF PARKING SPACE ONLY. ALBERTA  
HEALTH SERVICES ENDORSERS TO PROTECT THE PROPERTY  
OF ITS PATRONS BUT WILL NOT BE RESPONSIBLE FOR LOSS  
OR DAMAGE TO CAR OR CONTENTS.  
NON TRANSFERABLE

\$17.00 76420000 07:27 PM

AMOUNT PAID

CREDIT CARD NUMBER

20/09/11 07:27 PM \$17.00

21/09/11 07:27 PM

DATE ISSUED TIME ISSUED AMOUNT PAID  
DETACH RECEIPT FROM TICKET

EXPIRATION DATE EXPIRATION TIME  
LEAVE ON DASH - THIS SIDE UP

RAY

= TRANSACTION RECEIPT =

Checker/Yellow Cabs  
316 Meridian Road SE  
Calgary, AB T2A 1X2  
403 299-9999

ACCT TYPE: CASH/VOUCHER  
DATE/TIME:  
11/09/28 13:10:35

VEH/DRV: 1071 / 8449  
GST#: 8022405266

FARE: \$ 9.52  
FLAT: \$000.00  
EXTRAS: \$000.00  
GST: \$ 0.48

FA+FL+EX+TAX: \$ 10.00  
TIP: \$000.00  
DISCOUNT: \$000.00

TOTAL: \$ 10.00

DISPLAY THIS SIDE UP ON DASHBOARD

EXPIRATION DATE 21/10/11 12:31 PM  
EXPIRATION TIME 20/10/11 12:31 PM

AMOUNT PAID \$17.00 76370000 12:31 PM

RECEIPT 5051602

PRECISE PARKLINK  
CHARGES ARE FOR THE USE OF THE PARKING SPACE ONLY  
WE WILL NOT BE RESPONSIBLE FOR LOSS OR DAMAGE  
TO CAR OR CONTENTS, HOWEVER CAUSED, INCLUDING  
BUT NOT LIMITED TO FIRE, THEFT OR COLLISION

NON TRANSFERABLE 5051602

DISPLAY THIS SIDE UP ON DASHBOARD

EXPIRATION DATE 20/10/11 05:24 PM  
EXPIRATION TIME 20/10/11 03:54 PM

AMOUNT PAID \$ 6.75 76370000 03:54 PM

RECEIPT 5051631

PRECISE PARKLINK  
CHARGES ARE FOR THE USE OF THE PARKING SPACE ONLY  
WE WILL NOT BE RESPONSIBLE FOR LOSS OR DAMAGE  
TO CAR OR CONTENTS, HOWEVER CAUSED, INCLUDING  
BUT NOT LIMITED TO FIRE, THEFT OR COLLISION

NON TRANSFERABLE 5051631

DISPLAY THIS SIDE UP ON DASHBOARD

EXPIRATION DATE 18/10/11 11:12 AM  
EXPIRATION TIME 18/10/11 09:12 PM

AMOUNT PAID \$ 9.00 76370000 09:12 PM

PRECISE PARKLINK  
NON TRANSFERABLE 5051407

APPLICANT COPY RECEIPT 5051407

DETACH RECEIPT FROM TICKET

DETACH RECEIPT FROM TICKET

DETACH RECEIPT FROM TICKET

APPLICANT COPY

Alberta Health Services

TRAVEL, HOSPITALITY & HOSTING EXPENSE CLAIM FORM

PLEASE DO NOT USE ENTER KEY TO NAVIGATE THIS FORM → USE TAB, ARROW KEYS OR MOUSE

**SECTION A – Employee Details (for AHS Staff ONLY)**

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

Employee # (old) \_\_\_\_\_ Employee # (E-People): \_\_\_\_\_ Name: Glenda Coleman-Miller

Position (Title): Vice President Location: UAM (1), 17(4) Dept: Site Admin Out-of-Province Travel:

Union Name: \_\_\_\_\_ Business Phone #: 407-8009 Travel Period from: \_\_\_\_\_ to \_\_\_\_\_

What former entity payroll system is the employee currently being paid from? (Please ✓ one from below)

<input type="checkbox"/> AADAC	<input type="checkbox"/> Calgary Health	<input type="checkbox"/> East Central
<input type="checkbox"/> Alberta Cancer Board	<input checked="" type="checkbox"/> Capital Health	<input type="checkbox"/> Northern Lights
<input type="checkbox"/> Alberta Mental Health Board	<input type="checkbox"/> Chinook	<input type="checkbox"/> Palliser Health
<input type="checkbox"/> Aspen	<input type="checkbox"/> David Thompson	<input type="checkbox"/> Peace Country

**SECTION B – Finance Coding & Total Claim – Complete separate Page 2 for each Functional Centre**

Finance Code / Accounting Distribution → Expense Object Code (EOC)/secondary code not required in this section

Bal Unit (3 char)	Location (4 char)	Functional Centre (FC) (11 char)	pg	Travel \$s	pg	Other \$s	Total
101	0300	71110100064	2A	\$656.49	3	\$0.00	\$656.49
			2B		3		
			2C		3		
			2D		3		
Converted Foreign Currency \$s							
Less Cash Advance if applicable							
→ Claim should include a minimum of 2 pages + receipts						<b>TOTAL CLAIM</b>	\$656.49

**IMPORTANT NOTE → Applicable to all Sections A to F**  
 If this form is not filled in correctly, legibly and completely, the form will be returned. In order to facilitate processing of this claim, please review the following notes –

- Email approvals, physical signature stamp or similar device are not acceptable
- Employee # refers to the number indicated on employee's pay stub
- Out-of-Province Travel – the approver **MUST** ensure all documentation and approval levels are compliant as per the Travel Policy **BEFORE** submission to Accounts Payable

Alberta Health Services  
 Accounts Payable  
 NOV 09 2011  
 RECEIVED

**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 approval signatures required as well as DOFA level (delegation of authority level) and Position # of the approver.

Claim Prepared by (PRINT ONLY) Deidre Rainey Phone # 407-8009

I hereby certify that the expenses listed above are in accordance to applicable policies and was incurred on Alberta Health Services business and have not been previously claimed by me or on my behalf from Alberta Health Services or other organization.

Employee Signature: *Glenda Coleman-Miller* Date: 2011-11-04

I hereby certify that I have reviewed the expenses and they are in accordance with the applicable policies (Policy #'s CF-03, CF-04). Approved claim form with receipts should be sent by the approver directly to Accounts Payable for processing.

Approved By (PRINT ONLY) Mike Conroy	DOFA level	Position #	Phone # 407-2820
Signature: <i>[Signature]</i>	Title: SVP, Edmonton Zone		Date:
Approved By (PRINT ONLY)	DOFA level	Position #	Phone #
Signature:	Title:		Date:

NOTE: Expense claims must be properly authorized and appropriately supported in accordance with Alberta Health Services Policies  
 - 1 of 3 -

*Ruby*

**EXPENSE CLAIM DETAILS**

**Enter Finance Coding as per page 1** → **101. 0300.71110100064** (ba unit (3 char), location (4 char), and functional centre (11 char))

**Page 2** (enter A, B or C as required) → **A**

Please print extra copies of this page if expenses incurred are for multiple FC's (one FC per page) OR additional lines required for the same FC. Label this first page with A, and each additional page continue labeling with B, C etc. →

**SECTION C Travel & Education Expenses** **NOTE: If expenses do not fall into these categories, go to SECTION D**

Ensure separate lines are used for claim items that differ in province of expense. Enter total \$ amount on slip, **DO NOT** separate GST. Secondary/Expense codes are not required to be indicated in this section as they are pre-determined by the system.

Date (dd/mm/yy)	Purpose of Travel/Education	Prov of Exp (ie AB, BC, etc)	Hotel \$	Meals \$ (Type B, L, D or A for All) w/o receipt or per diem		Taxi \$	Transportation \$			Course Reg / Material \$	Mileage (km)		
				Type	w/receipt		Airfare	Bus	Parking			Rental Car	
26/10/11	Town Council Meetings in Wabasca & High Prairie	AB		B	7.15							966.00	
	Re: Dialysis (Food costs for Glenda, Deanna Paulson, Dr. Jindal and Kim Gaudet and North Zone VP/MD for lunch)			L	96.02								
				D	65.49								
(sum applicable columns) SUBTOTALS													
							168.66	0.00	0.00	0.00		Total Kms	966.00

**TRAVEL EXPENSE LIMITS** – (Refer to CF-04 for terms and conditions, except where collective agreement specifies otherwise.)

**Meal Expenses & Allowances**  
 Actual cost of the meal as shown on the receipt, excluding alcoholic beverages, including up to 15% gratuity and GST to a maximum (with or without receipt) as indicated below.  
 a) Breakfast → \$10 b) Lunch → \$12 c) Dinner → \$21

Enter \$0.505 OR rate per Union Agreement **0.505**

Mileage \$ **487.83**

Travel \$'s Subtotal **168.66**

Enter on page 1 **TOTAL TRAVEL \$s 656.49**

Please enter above total for each page 2 separately onto page 1, Section B





s.17(1), 17(4)(e.1)

AMIRO'S STEAKHOUSE  
4651, 53RD AVENUE  
HIGH PRAIRIE AB

CARD TYPE VISA  
DATE 2011/10/26  
TIME 19:17:08  
RECEIPT NUMBER  
C30890935-001-552-037-0

PURCHASE AMOUNT \$57.49  
TIP \$8.00  
TOTAL \$65.49

USA 000000031010  
DEBIT FAS2A756ED  
000008000  
3304F7836508888

PPF 01  
UTH# 01 01-027  
THANK YOU

CARDHOLDER COPY

IMPORTANT - RETAIN THIS COPY FOR YOUR RECORDS

SALE RECEIPT  
Store #14757  
Subway Sandwiches & Salads  
4812 50th St Unit 103  
S.S.T. #8663927745  
PH#780-675-5568  
FAX#780-675-2376  
Athabasca

Trans# 39 Clerk 20  
Receipt # 0000484294  
Reg-ID 102611  
PRICE MEMO PLU  
ITEM QTY

LG COFFEE	1	\$ 2.00
MUFFIN	1	\$ 1.89
SM COFFEE	1	\$ 1.50
COOKIE	1	\$ 0.71
COOKIE	1	\$ 0.71

SUBTOTAL \$ 6.81  
GST 0.34

TAKE-OUT \*\*TOTAL \$ 7.15  
Cash AMT TEND \$ 10.00

CHANGE DUES \$ 2.85

How'd we do? Get a free cookie  
Take 1 min. survey [www.tellsubway.com](http://www.tellsubway.com)

**Grill & Catering Co.**

) 891-2021  
673  
Alberta  
2K0

SOUTHGATE GRILL  
1010 HISCANNY RD

BARABSA AB T96-2K0  
TEL (403) 642-7598

TERM ID: C4106922 BATCH#: 461  
SHIFT#: 009

**Sale**  
INVT#: 000003212  
VISA

Application Label: VISA  
AID: 46000000321210  
TVR: 00 00 00 00 00

No. of Guest:

Date: s.17(1), 17(4)(e.1)

Amount: \$ 86.02  
TIP: \$ 10.00

Total: CAD\$ 96.02

APPROVED 034163  
001-00

26-Oct-11 12:41:15

CUSTOMER COPY  
THANK YOU

*Indulge Your Senses*  
*Have a Nice Day!*

SUB-TOTAL	
G.S.T.	
TOTAL	
DATE	
SUB-TOTAL	
G.S.T.	
TOTAL	



From the desk of:

**Glenda Coleman-Miller**

**Vice President  
UAH/Stollery/Mazankowski  
780.407.8009**

Trip to High Prairie & Watrous  
mileage - 966 km.

Meals for Ben <sup>Kim Gaudet</sup>  
Dr. Jundal  
Debra Paulson  
plus 2 staff from  
the North Base who  
joined us for the meetings

TRAVEL, HOSPITALITY & HOSTING EXPENSE CLAIM FORM

PLEASE DO NOT USE ENTER KEY TO NAVIGATE THIS FORM → USE TAB, ARROW KEYS OR MOUSE

**SECTION A – Employee Details (for AHS Staff ONLY)**

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

Employee # (old) \_\_\_\_\_ Employee # (E-People): \_\_\_\_\_ Name: Glenda Coleman-Miller

Position (Title): Vice President Location: UAH 17(4)(g)(i) Dept: Site Admin Out-of-Province Travel:

Union Name: I7(1), I7(4)(g)(i) Business Phone #: 407-8009 Travel Period from: \_\_\_\_\_ to \_\_\_\_\_

What former entity payroll system is the employee currently being paid from? (Please ✓ one from below)

<input type="checkbox"/> AADAC	<input type="checkbox"/> Calgary Health	<input type="checkbox"/> East Central
<input type="checkbox"/> Alberta Cancer Board	<input checked="" type="checkbox"/> Capital Health	<input type="checkbox"/> Northern Lights
<input type="checkbox"/> Alberta Mental Health Board	<input type="checkbox"/> Chinook	<input type="checkbox"/> Palliser Health
<input type="checkbox"/> Aspen	<input type="checkbox"/> David Thompson	<input type="checkbox"/> Peace Country

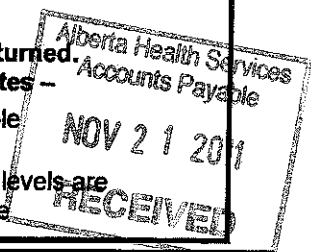
**SECTION B – Finance Coding & Total Claim – Complete separate Page 2 for each Functional Centre**

Finance Code / Accounting Distribution → Expense Object Code (EOC)/secondary code not required in this section

Bal Unit (3 char)	Location (4 char)	Functional Centre (FC) (11 char)	pg	Travel \$s	pg	Other \$s	Total
101	0300	71110100064	2A	\$167.28	3	\$0.00	\$167.28
			2B		3		
			2C		3		
			2D		3		
Converted Foreign Currency \$s							
Less Cash Advance if applicable							
→ Claim should include a minimum of 2 pages + receipts							
<b>TOTAL CLAIM</b>							\$167.28

**IMPORTANT NOTE → Applicable to all Sections A to F**  
 If this form is not filled in correctly, legibly and completely, the form will be returned.  
 In order to facilitate processing of this claim, please review the following notes –

- Email approvals, physical signature stamp or similar device are not acceptable
- Employee # refers to the number indicated on employee's pay stub
- Out-of-Province Travel – the approver **MUST** ensure all documentation and approval levels are compliant as per the Travel Policy **BEFORE** submission to Accounts Payable



**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 approval signatures required as well as DOFA level (delegation of authority level) and Position # of the approver.

Claim Prepared by (PRINT ONLY) Deidre Rainey Phone # 407-8009

I hereby certify that the expenses listed above are in accordance to applicable policies and was incurred on Alberta Health Services business and have not been previously claimed by me or on my behalf from Alberta Health Services or other organization.

Employee Signature: *Glenda Coleman-Miller* Date: 2011-11-15

I hereby certify that I have reviewed the expenses and they are in accordance with the applicable policies (Policy #'s CF-03, CF-04). Approved claim form with receipts should be sent by the approver directly to Accounts Payable for processing.

Approved By (PRINT ONLY) Mike Conroy	DOFA level	Position #	Phone # 407-2820
Signature: <i>[Signature]</i>	Title: SVP, Edmonton Zone	Date:	
Approved By (PRINT ONLY)	DOFA level	Position #	Phone #
Signature:	Title:	Date:	

NOTE: Expense claims must be properly authorized and appropriately supported in accordance with Alberta Health Services Policies  
 - 1 of 3 -

**EXPENSE CLAIM DETAILS**

**Enter Finance Coding as per page 1** → **101.0300.71110100064** (bal unit (3 char), location (4 char), and functional centre (11 char))

**Page 2** (enter A, B or C as required) → **A**

**SECTION C Travel & Education Expenses**

**NOTE: If expenses do not fall into these categories, go to SECTION D**

Ensure separate lines are used for claim items that differ in province of expense. Enter total \$ amount on slip, **DO NOT** separate GST. Secondary/Expense codes are not required to be indicated in this section as they are pre-determined by the system.

Date (dd/mm/yy)	Purpose of Travel/Education	Prov of Exp (ie AB, BC, etc)	Hotel \$	Meals \$ (Type B, L, D or A for All)		Taxi \$	Transportation \$			Course Reg / Material \$	Mileage (km)		
				Type	w/receipt		w/o receipt or per diem	Airfare	Bus.			Parking	Rental Car
05/11/11	AHS Foundations Leadership Forum	AB	167.28										
<b>SUBTOTALS</b>			167.28					0.00	0.00			0.00	
(sum applicable columns)													
<b>TRAVEL EXPENSE LIMITS - (Refer to CF-04 for terms and conditions, except where collective agreement specifies otherwise.)</b>													
<b>Meal Expenses &amp; Allowances</b>													
Actual cost of the meal as shown on the receipt, excluding alcoholic beverages, including up to 15% gratuity and GST to a maximum (with or without receipt) as indicated below.													
a) Breakfast → \$10 b) Lunch → \$12 c) Dinner → \$21													
							Enter \$0.505 OR rate per Union Agreement						
							Mileage \$						
							Travel \$'s Subtotal					167.28	
							Enter on page 1 TOTAL TRAVEL \$					167.28	
Please enter above total for each page 2 separately onto page 1, Section B													



# APPLICANT COPY

Four Points By Sheraton Calgary Airport  
 2875 Sunridge Way NE  
 Calgary, AB T1Y7K7  
 Canada  
 Tel: 403-648-3180 Fax: 403-648-3179

Glenda Coleman-Miller	Page Number : 1	Invoice Nbr: 111392
	Guest Number: 81068	Arrive Date: 04-NOV-11 17:17
	Folio ID : EX-A	Depart Date: 05-NOV-11
	No. Of Guest: 1	
	Room Number : 417	
Email:	Room Rate : 149.00	
s.17(1), 17(4)(g)(i)	Club Account:	s.17(1), 17(4)(g)(i)

Tax ID: 829610872 RT0001  
 Four Points Calgary 05-NOV-11 02:08 KLESTER

Date	Reference	Description	Amount
04-NOV-11	RT417	Room Charge	149.00
04-NOV-11	RT417	GST	7.45
04-NOV-11	RT417	Tourism Levy	5.96
04-NOV-11	RT417	DMF Tax	4.87
05-NOV-11	VI	Visa	-167.28
		** Total Charges	167.28
		** Total Credits	-167.28
		*** Balance	0.00

For your convenience, we have prepared this zero-balance folio indicating a \$0 balance on your account. Please be advised that any charges not reflected on this folio will be charged to the credit card on file with the hotel. While this folio reflects a \$0 balance, your credit card may not be charged until after your departure. You are ultimately responsible for paying all of your folio charges in full.

Continued on the next page

APPLICANT COPY

Four Points By Sheraton Calgary Airport  
2875 Sunridge Way NE  
Calgary, AB T2L 7K7  
Canada  
Tel: 403-648-3180 Fax: 403-648-3181

Glenda Coleman-Miller

Page Number : 2  
Guest Number: 81068  
Folio ID : EX-A  
No. Of Guest: 1  
Room Number : 417  
Room Rate : 149.00  
Club Account:

Invoice Nbr: 111392  
Invoice Date: 04-NOV-11 17:17  
Start Date: 05-NOV-11

Email:

s.17(1), 17(4)(g)(i)

s.17(1), 17(4)(g)(i)

Amount CAD

0.00  
0.00  
0.00  
0.00  
0.00

As a Starwood Preferred Guest you have earned at least 29  
this visit

s.17(1), 17(4)(g)(i)

airpoints for





Alberta Health Services

TRAVEL, HOSPITALITY & HOSTING EXPENSE CLAIM FORM

PLEASE DO NOT USE ENTER KEY TO NAVIGATE THIS FORM → USE TAB, ARROW KEYS OR MOUSE

SECTION A - Employee Details (for AHS Staff ONLY)

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

Employee # (old): \_\_\_\_\_ Employee # (E-People): \_\_\_\_\_ Name: Glenda Coleman-Miller

Position (Title) (4 char): \_\_\_\_\_ Location: UAH 7(4)(g)(i) Dept: Site Admin Out-of-Province Travel:

Union Name: \_\_\_\_\_ Business Phone #: 407-8009 Travel Period from: \_\_\_\_\_ to \_\_\_\_\_

What former entity payroll system is the employee currently being paid from? (Please ✓ one from below)

<input type="checkbox"/> AADAC	<input type="checkbox"/> Calgary Health	<input type="checkbox"/> East Central
<input type="checkbox"/> Alberta Cancer Board	<input checked="" type="checkbox"/> Capital Health	<input type="checkbox"/> Northern Lights
<input type="checkbox"/> Alberta Mental Health Board	<input type="checkbox"/> Chinook	<input type="checkbox"/> Palliser Health
<input type="checkbox"/> Aspen	<input type="checkbox"/> David Thompson	<input type="checkbox"/> Peace Country

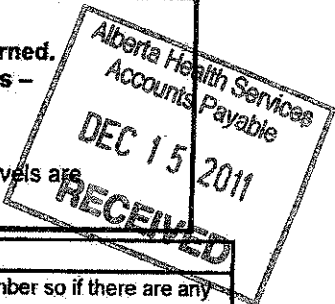
SECTION B - Finance Coding & Total Claim - Complete separate Page 2 for each Functional Centre

Finance Code / Accounting Distribution → Expense Object Code (EOC)/secondary code not required in this section

Bal Unit (3 char)	Location (4 char)	Functional Centre (FC) (11 char)	pg	Travel \$s	pg	Other \$s	Total
101	0300	71110100064	2A	\$98.50	3	\$0.00	\$98.50
			2B		3		
			2C		3		
			2D		3		
Converted Foreign Currency \$s							
Less Cash Advance if applicable							
→ Claim should include a minimum of 2 pages + receipts							TOTAL CLAIM \$98.50

**IMPORTANT NOTE** → Applicable to all Sections A to F  
 If this form is not filled in correctly, legibly and completely, the form will be returned.  
 In order to facilitate processing of this claim, please review the following notes -

- Email approvals, physical signature stamp or similar device are not acceptable
- Employee # refers to the number indicated on employee's pay stub
- Out-of-Province Travel - the approver **MUST** ensure all documentation and approval levels are compliant as per the Travel Policy **BEFORE** submission to Accounts Payable



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 approval signatures required as well as DOFA level (delegation of authority level) and Position # of the approver.

Claim Prepared by (PRINT ONLY) Deidre Rainey Phone # 407-8009

I hereby certify that the expenses listed above are in accordance to applicable policies and was incurred on Alberta Health Services business and have not been previously claimed by me or on my behalf from Alberta Health Services or other organization.

Employee Signature: *[Signature]* Date: 2011-12-11

I hereby certify that I have reviewed the expenses and they are in accordance with the applicable policies (Policy #'s CF-03, CF-04). Approved claim form with receipts should be sent by the approver directly to Accounts Payable for processing.

Approved By (PRINT ONLY) Mike Conroy	DOFA level	Position #	Phone # 407-2820
Signature: <i>[Signature]</i>	Title: SVP, Edmonton Zone		Date:
Approved By (PRINT ONLY)	DOFA level	Position #	Phone #
Signature:	Title:		Date:

NOTE: Expense claims must be properly authorized and appropriately supported in accordance with Alberta Health Services Policies

EXPENSE CLAIM DETAILS

Enter Finance Coding as per page 1 → 101. 0300.71110100064  
 bal unit (3 char), location (4 char), and functional centre (11 char)

Page 2 (enter A, B or C as required) → A

Please print extra copies of this page if expenses incurred are for multiple FC's (one FC per page) OR additional lines required for the same FC. Label this first page with A, and each additional page continue labeling with B, C etc. →

SECTION C		Travel & Education Expenses										SECTION D	
NOTE: If expenses do not fall into these categories, go to SECTION D													
Ensure separate lines are used for claim items that differ in province of expense. Enter total \$ amount on slip, DO NOT separate GST. Secondary/Expense codes are not required to be indicated in this section as they are pre-determined by the system.													
Date (dd/mm/yy)	Purpose of Travel/Education	Prov of Exp (ie AB, BC, etc)	Hotel \$	Meals \$ (Type B, L, D or A for All)		Taxi \$	Transportation \$				Course Reg / Material \$	Mileage (km)	
				Type	w/receipt		w/o receipt or per diem	Airfare	Bus	Parking			Rental Car
26/09/11	CCHL Conference	ON				60.00							
27/07/11	ED Pt Flow Workshop at RAH	AB				20.00							
14/11/11	AIW Workshop at RAH	AB						15.00					
17/11/11	CK Hui Meeting at RAH	AB						3.50					
				(sum applicable columns) SUBTOTALS				80.00	0.00	0.00	18.50	0.00	Total Kms
<p>TRAVEL EXPENSE LIMITS – (Refer to CF-04 for terms and conditions, except where collective agreement specifies otherwise.)</p> <p>Meal Expenses &amp; Allowances</p> <p>Actual cost of the meal as shown on the receipt, excluding alcoholic beverages, including up to 15% gratuity and GST to a maximum (with or without receipt) as indicated below.</p> <p>a) Breakfast → \$10    b) Lunch → \$12    c) Dinner → \$21</p>													
Enter \$0.505 OR rate per Union Agreement													
Mileage \$s													
Travel \$'s Subtotal												98.50	
Enter on page 1 TOTAL TRAVEL \$s												98.50	
Please enter above total for each page 2 separately onto page 1, Section B													

**SECTION D Other Expenses** **EXPENSE CLAIM DETAILS**  
**NOTE: If expenses are for travel or education (courses etc) go to SECTION C**

→ If no "Other" expenses listed below **MUST** have a secondary/expense code indicated!  
 → If no "Other" expenses are being claimed, this page does not have to be submitted.  
 → Gas receipts & business insurance are claimed here in Section D - Other Expenses.

**Subtotal "Other Expenses" for each functional centre separately**  
**and enter each subtotal on page 1**



Date (dd/mm/yy)	Purpose of Expense	Functional Centre (ie. 101.0767.71355000007)	Secondary/Expense Code (ie: 4100000)	If GST is included on till slip/receipt, enter total amount into column A, if not included enter amount into column B		TOTAL Other \$s
				A-GST on receipt	B-GST not on receipt	

227

**SECTION E Foreign Currency**  
**ONLY ENTER IN THIS SECTION IF AMOUNT NOT CONVERTED INTO CDN \$'S.**  
 All expenses will be paid in CDN \$'s and the exchange rate will be used from the Bank of Canada for the date of the expense. Accounts Payable will complete the currency exchange if not indicated on the receipt/document.

Date (dd/mm/yy)	Purpose of Expense	Functional Centre (ie. 101.0767.71355000007)	Secondary/Expense Code (ie: 4100000)	Foreign Currency Amt (\$)	Foreign Currency	For AP use ONLY	
						Exch Rate	CDN Value
Total Converted \$s							

**Expenses Paid (Retain a copy for your records)**  
**Do not include amounts paid by Alberta Health Services or reimbursed / reimbursable by another organization.**

**LEAVE ON DASH - THIS SIDE UP**  
EXPIRATION DATE      EXPIRATION TIME

15/11/11 08:14 AM

AMOUNT PAID  
\$ 15.00 76430000 08:14 AM NETP

3514580

Alberta Health Services

Alberta Health Services  
CHARGES ARE FOR USE OF PARKING SPACE ONLY. ALBERTA HEALTH SERVICES ENDEAVOURS TO PROTECT THE PROPERTY OF ITS PATRONS BUT WILL NOT BE RESPONSIBLE FOR LOSS OR DAMAGE TO CAR OR CONTENTS.  
NON TRANSFERABLE

**DETACH RECEIPT FROM TICKET**  
DATE ISSUED      TIME ISSUED      AMOUNT PAID

14/11/11 08:14 AM \$ 15.00

CREDIT CARD NUMBER  
NETP DAILY

3514580

Alberta Health Services

Alberta Health Services  
**RECEIPT**

**LEAVE ON DASH - THIS SIDE UP**  
EXPIRATION DATE      EXPIRATION TIME

17/11/11 11:00 AM

AMOUNT PAID  
\$ 3.50 76440000 10:00 AM

3495092

Alberta Health Services

Alberta Health Services  
CHARGES ARE FOR USE OF PARKING SPACE ONLY. ALBERTA HEALTH SERVICES ENDEAVOURS TO PROTECT THE PROPERTY OF ITS PATRONS BUT WILL NOT BE RESPONSIBLE FOR LOSS OR DAMAGE TO CAR OR CONTENTS.  
NON TRANSFERABLE

**DETACH RECEIPT FROM TICKET**  
DATE ISSUED      TIME ISSUED      AMOUNT PAID

17/11/11 10:00 AM \$ 3.50

CREDIT CARD NUMBER

3495092

Alberta Health Services

Alberta Health Services  
**RECEIPT**

Receipt From Taxicab # press  
Date \_\_\_\_\_  
From \_\_\_\_\_  
To \_\_\_\_\_  
Amount \$ 6.00  
Signature [Signature]

ST. ALBERTA, ALBERTA  
S.17(1), 17(4)(g)(i)

GST# \_\_\_\_\_  
Date: July 27/11 Amount: 20.00  
Driver: RHA Car #: 362  
From: \_\_\_\_\_  
To: \_\_\_\_\_

**YELLOW CAR**

780-462-3456

**TRAVEL, HOSPITALITY & HOSTING EXPENSE CLAIM FORM**

PLEASE DO NOT USE ENTER KEY TO NAVIGATE THIS FORM → USE TAB, ARROW KEYS OR MOUSE

<b>SECTION A – Employee Details (for AHS Staff ONLY)</b>							
→ Enter Employee # (old) and Employee # (E-People) if you have migrated to the New E-People payroll system. → Indicate N/A in the Employee # (E-People) if you have not migrated to the New E-People payroll system. → If you are a new employee and payroll has migrated to E-People you will only have an Employee # (E-People).							
Employee # (old)		Employee # (E-People):		Name: Glenda Coleman-Miller			
Position (Title): Vice President 17(1), 17(4)(g)(i)		Location: UAH. 17(1), 17(4)(g)(i)		Dept: Site Admin		Out-of-Province Travel: <input type="checkbox"/>	
Union Name:		Business Phone #: 407-8009		Travel Period from: to			
What former entity payroll system is the employee currently being paid from? (Please ✓ one from below)							
<input type="checkbox"/> AADAC		<input type="checkbox"/> Calgary Health		<input type="checkbox"/> East Central			
<input type="checkbox"/> Alberta Cancer Board		<input checked="" type="checkbox"/> Capital Health		<input type="checkbox"/> Northern Lights			
<input type="checkbox"/> Alberta Mental Health Board		<input type="checkbox"/> Chinook		<input type="checkbox"/> Palliser Health			
<input type="checkbox"/> Aspen		<input type="checkbox"/> David Thompson		<input checked="" type="checkbox"/> Peace Country			
<b>SECTION B – Finance Coding &amp; Total Claim – Complete separate Page 2 for each Functional Centre</b>							
Finance Code / Accounting Distribution → Expense Object Code (EOC)/secondary code not required in this section							
Bal Unit (3 char)	Location (4 char)	Functional Centre (FC) (11 char)	pg	Travel \$s	pg	Other \$s	Total
101	0300	71110100064	2A	\$47.32	3	\$0.00	\$47.32
			2B		3		
			2C		3		
			2D		3		
				Converted Foreign Currency \$s			
				Less Cash Advance if applicable			
→ Claim should include a minimum of 2 pages + receipts						<b>TOTAL CLAIM</b>	
						\$47.32	

**IMPORTANT NOTE → Applicable to all Sections A to F**  
 If this form is not filled in correctly, legibly and completely, the form will be returned.  
 In order to facilitate processing of this claim, please review the following notes –

- Email approvals, physical signature stamp or similar device are **not** acceptable.
- Employee # refers to the number indicated on employee's pay stub
- Out-of-Province Travel – the approver **MUST** ensure all documentation and approval levels are **compliant** as per the Travel Policy **BEFORE** submission to Accounts Payable

Alberta Health Services  
 Accounts Payable  
 FEB 01 2012  
 RECEIVED

<b>SECTION F - Authorization</b>			
If applicable, <b>print</b> 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 approval signatures required as well as DOFA level (delegation of authority level) and Position # of the approver.			
Claim Prepared by (PRINT ONLY) Deidre Rainey		Phone # 407-8009	
I hereby certify that the expenses listed above are in accordance to applicable policies and was incurred on Alberta Health Services business and have not been previously claimed by me or on my behalf from Alberta Health Services or other organization.			
Employee Signature: <i>Glenda Coleman-Miller</i>		Date:	
I hereby certify that I have reviewed the expenses and they are in accordance with the applicable policies (Policy #'s CF-03, CF-04). Approved claim form with receipts should be sent by the approver directly to Accounts Payable for processing.			
Approved By (PRINT ONLY) Mike Conroy		DOFA level	Position #
Signature:		Title: SVP, Edmonton Zone	
Date:		Phone #	
Approved By (PRINT ONLY)		DOFA level	Position #
Signature:		Title:	
Date:		Phone #	

 NOTE: Expense claims must be properly authorized and appropriately supported in accordance with Alberta Health Services Policies  
 - 1 of 3 -

**EXPENSE CLAIM DETAILS**

<b>Enter Finance Coding as per page 1</b> →	101. 0300.71110100064 bal unit (3 char), location (4 char), and functional centre (11 char)	<b>Page 2</b> (enter A, B or C as required) A
---	--	---

Please print extra copies of this page if expenses incurred are for multiple FC's (one FC per page) OR additional lines required for the same FC.  
Label this first page with A, and each additional page continue labeling with B, C etc. →

**SECTION C Travel & Education Expenses**

**NOTE: If expenses do not fall into these categories, go to SECTION D**  
 Ensure separate lines are used for claim items that differ in province of expense. Enter total \$ amount on slip, **DO NOT** separate GST.  
 Secondary/Expense codes are not required to be indicated in this section as they are pre-determined by the system.

Date (dd/mm/yy)	Purpose of Travel/Education	Prov of Exp (ie AB, BC, etc)	Meals \$ (Type B, L, D or A for All)		Taxi \$	Airfare	Transportation \$		Course Reg / Material \$	Mileage (km)
			Type	w/receipt			Bus	Parking		
17/10/11	ECC Meeting at RAH	AB					10.50			6.00
01/12/11	Provincial Leadership Meeting	AB					18.00			3.00
14/12/11	RAH Medicine Meetings	AB					11.25			6.00
(sum applicable columns) <b>SUBTOTALS</b>										
						0.00	0.00	39.75	0.00	Total Kms 15.00
TRAVEL EXPENSE LIMITS - (Refer to CF-04 for terms and conditions, except where collective agreement specifies otherwise.) <b>Meal Expenses &amp; Allowances</b> Actual cost of the meal as shown on the receipt, excluding alcoholic beverages, including up to 15% gratuity and GST to a maximum (with or without receipt) as indicated below. <b>a) Breakfast → \$10 b) Lunch → \$12 c) Dinner → \$21</b>										
						Enter \$0.505 OR rate per Union Agreement		0.505		
						Mileage \$\$		7.57		
						Travel \$'s Subtotal		47.32		
						Enter on page 1 TOTAL TRAVEL \$\$		47.32		

Please enter above total for each page 2 separately onto page 1, Section B

**SECTION D | Other Expenses** **EXPENSE CLAIM DETAILS**

**NOTE: If expenses are for travel or education (courses etc) go to SECTION C**

ALL "OTHER" expenses listed below **MUST** have a secondary/expense code indicated!  
 → If no "Other" expenses are being claimed, this page does not have to be submitted.  
 → Gas receipts & business insurance are claimed here in Section D - Other Expenses.

**Subtotal "Other Expenses" for each functional centre separately**  
**and enter each subtotal on page 1**

Date (dd/mm/yy)	Purpose of Expense	Functional Centre (ie. 101.0767.71355000007)	Secondary/Expense Code (ie: 4100000)	If GST is included on till slip/receipt, enter total amount into column A, if not included enter amount into column B A-GST on receipt    B-GST not on receipt	TOTAL Other \$\$
<b>Total</b>					

**SECTION E | Foreign Currency**

**ONLY ENTER IN THIS SECTION IF AMOUNT NOT CONVERTED INTO CDN \$'S.**  
 All expenses will be paid in CDN \$'s and the exchange rate will be used from the Bank of Canada for the date of the expense. Accounts Payable will complete the currency exchange if not indicated on the receipt/document.

Date (dd/mm/yy)	Purpose of Expense	Functional Centre (ie. 101.0767.71355000007)	Secondary/Expense Code (ie: 4100000)	Foreign Currency Amt (\$)	Foreign Currency Exch Rate	Foreign Currency CDN Value
<b>Total Converted \$</b>						

**Expenses Paid (Retain a copy for your records)**  
**Do not include amounts paid by Alberta Health Services or reimbursed / reimbursable by another organization.**

ROYAL ALEXANDRA HOSPITAL  
 ST PARKADE - PUBLIC PARKING  
 GST # R124072513  
**Best Copy Possible**  
 NORTH 5827  
 10/17/11 17:12 LH 1 AM 11 TXN# 65377  
 10/17/11 14:21 IN 10/17/11 17:12 Out  
 TXN# 211195  
 HOURLY FEE \$ 10.50  
 TOTAL FEE \$ 10.50  
 CASH PAID \$ 10.50-  
 Cash Tender \$ 10.50  
 Change Due \$ 0.00  
 GST Included in Price  
 Comments? - Email us:  
 provincialparking@  
 albertahealthservices.ca

ON DASH  
**umpark**  
**Best Copy Possible**  
 PHONE 780 420-1170  
 EARLY BIRD  
 Method  
 Time:  
 TICKET VOID IF RE-SOLD  
 PLACE THIS SIDE UP ON DASH  
 s.17(1), 17(4)(1)  
 6:00PM THU  
 DEC 01 11  
 PLACE TH  
 GST NO. 8873171291000  
 UNSTAMPED COPIES OF CHECK  
 F-SOLD

**LEAVE ON DASH - THIS SIDE UP**  
 EXPIRATION DATE 14/12/11 03:46 PM  
 EXPIRATION TIME 03:46 PM  
**DETACH RECEIPT FROM TICKET**  
 DATE ISSUED 14/12/11 01:16 PM  
 TIME ISSUED 01:16 PM  
 AMOUNT PAID \$11.25  
 AMOUNT PAID \$11.25  
 CREDIT CARD NUMBER 76370000 01:16 PM

2121424  
 Alberta Health Services  
 CHARGES ARE FOR USE OF PARKING SPACE ONLY. ALBERTA HEALTH SERVICES ENDEAVOURS TO PROTECT THE PROPERTY OF ITS PATRONS BUT WILL NOT BE RESPONSIBLE FOR LOSS OR DAMAGE TO CAR OR CONTENTS.  
 NON TRANSFERABLE  
 2121424  
 Alberta Health Services  
 RECEIPT



**TRAVEL, HOSPITALITY & HOSTING EXPENSE CLAIM FORM**

PLEASE DO NOT USE ENTER KEY TO NAVIGATE THIS FORM → USE TAB, ARROW KEYS OR MOUSE

**SECTION A – Employee Details (for AHS Staff ONLY)**

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

Employee # (old) \_\_\_\_\_ Employee # (E-People): \_\_\_\_\_ Name: Glenda Coleman-Miller

Position (Title): Vice President Location: UAH7(4)(g)(i) Dept: Site Admin Out-of-Province Travel:

Union Name: \_\_\_\_\_ Business Phone #: 407-8009 Travel Period from: \_\_\_\_\_ to \_\_\_\_\_

What former entity payroll system is the employee currently being paid from? (Please ✓ one from below)

<input type="checkbox"/> AADAC	<input type="checkbox"/> Calgary Health	<input type="checkbox"/> East Central
<input type="checkbox"/> Alberta Cancer Board	<input checked="" type="checkbox"/> Capital Health	<input type="checkbox"/> Northern Lights
<input type="checkbox"/> Alberta Mental Health Board	<input type="checkbox"/> Chinook	<input type="checkbox"/> Palliser Health
<input type="checkbox"/> Aspen	<input type="checkbox"/> David Thompson	<input type="checkbox"/> Peace Country

**SECTION B – Finance Coding & Total Claim – Complete separate Page 2 for each Functional Centre**

Finance Code / Accounting Distribution → Expense Object Code (EOC)/secondary code not required in this section

Bal Unit (3 char)	Location (4 char)	Functional Centre (FC) (11 char)	pg	Travel \$s	pg	Other \$s	Total
101	0300	71110100064	2A	\$0.00	3	\$1066.16	\$1066.16
			2B		3		
			2C		3		
			2D		3		
				Converted Foreign Currency \$s			
				Less Cash Advance if applicable			
→ Claim should include a minimum of 2 pages of receipts						<b>TOTAL CLAIM</b>	\$1,066.16

Alberta Health Services  
Accounts Payable  
MAR 30 2012

RECEIVED

**IMPORTANT NOTE → Applicable to all Sections A to F**  
 If this form is not filled in correctly, legibly and completely, the form will be returned.  
 In order to facilitate processing of this claim, please review the following notes –

- Email approvals, physical signature stamp or similar device are **not** acceptable
- Employee # refers to the number indicated on employee's pay stub
- Out-of-Province Travel – the approver **MUST** ensure all documentation and approval levels are **compliant** as per the Travel Policy **BEFORE** submission to Accounts Payable

**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 approval signatures required as well as DOFA level (delegation of authority level) and Position # of the approver.

Claim Prepared by (PRINT ONLY) Fran Algar Phone # 407-8009

I hereby certify that the expenses listed above are in accordance to applicable policies and was incurred on Alberta Health Services business and have not been previously claimed by me or on my behalf from Alberta Health Services or other organization.

Employee Signature: *Glenda Coleman-Miller* Date: *March 29/12*

I hereby certify that I have reviewed the expenses and they are in accordance with the applicable policies (Policy #'s CF-03, CF-04). Approved claim form with receipts should be sent by the approver directly to Accounts Payable for processing.

Approved By (PRINT ONLY) Mike Conroy DOFA level *3a* Position # \_\_\_\_\_ Phone # 407-2820

Signature: \_\_\_\_\_ Title: SVP, Edmonton Zone Date: \_\_\_\_\_

Approved By (PRINT ONLY) \_\_\_\_\_ DOFA level \_\_\_\_\_ Position # \_\_\_\_\_ Phone # \_\_\_\_\_

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

NOTE: Expense claims must be properly authorized and appropriately supported in accordance with Alberta Health Services Policies

*Ruby*

**EXPENSE CLAIM DETAILS**

<b>Enter Finance Coding as per page 1</b> →	101. 0300.711110100064 bal unit (3 char), location (4 char), and functional centre (11 char)	<b>Page 2</b> (enter A, B or C as required) A
---	---	---

**SECTION C Travel & Education Expenses**      **NOTE: If expenses do not fall into these categories, go to SECTION D**

Ensure separate lines are used for claim items that differ in province of expense. Enter total \$ amount on slip. **DO NOT** separate GST. Secondary/Expense codes are not required to be indicated in this section as they are pre-determined by the system.

Date (dd/mm/yy)	Purpose of Travel/Education	Prov of Exp (ie AB, BC, etc)	Hotel \$	Meals \$ (Type B, L, D or A for All)		Taxi \$	Transportation \$				Course Reg / Material \$	Mileage (km)	
				Type	w/receipt		w/o receipt or per diem	Airfare	Bus	Parking			Rental Car
24/01/12	Holiday Inn - Difficult Disch.	AB	684.40										
01/03/12	Meetings	AB	226.96			71.75				9.00			
05/03/12	NARP Team to Lac La Biche	AB		L	74.05								
(sum applicable columns) SUBTOTALS					911.36	74.05	71.75	0.00	0.00	9.00	0.00		Total Kms

**TRAVEL EXPENSE LIMITS** - (Refer to CF-04 for terms and conditions, except where collective agreement specifies otherwise.)  
**Meal Expenses & Allowances**  
 Actual cost of the meal as shown on the receipt, excluding alcoholic beverages, including up to 15% gratuity and GST to a maximum (with or without receipt) as indicated below.  
 a) Breakfast → \$10    b) Lunch → \$12    c) Dinner → \$21

Enter on page 1 TOTAL TRAVEL \$s      Enter on page 1 TOTAL TRAVEL \$s

Enter \$0.505 OR rate per Union Agreement      Mileage \$s

Travel \$'s Subtotal      1066.16

Please enter above total for each page 2 separately onto page 1, Section B

**EXPENSE CLAIM DETAILS**

**SECTION D Other Expenses**

**NOTE:** If expenses are for travel or education (courses etc) go to SECTION C

ALL "OTHER" expenses listed below MUST have a secondary/expense code indicated!

→ If no "Other" expenses are being claimed, this page does not have to be submitted.

→ Gas receipts & business insurance are claimed here in Section D – Other Expenses.

**Subtotal "Other Expenses" for each functional centre separately**  
**and enter each subtotal on page 1**



Date (dd/mm/yy)	Purpose of Expense	Functional Centre (ie. 101.0767.71355000007)	Secondary/Expense Code (ie. 4100000)	If GST is included on bill/slip/receipt, enter total amount into column A, if not included enter amount into column B		TOTAL Other \$\$
				A-GST on receipt	B-GST not on receipt	

**SECTION E Foreign Currency**

**ONLY ENTER IN THIS SECTION IF AMOUNT NOT CONVERTED INTO CDN \$\$'S.**  
 All expenses will be paid in CDN \$\$'s and the exchange rate will be used from the Bank of Canada for the date of the expense. Accounts Payable will complete the currency exchange if not indicated on the receipt/document.

Date (dd/mm/yy)	Purpose of Expense	Functional Centre (ie. 101.0767.71355000007)	Secondary/Expense Code (ie. 4100000)	Foreign Currency Amt (\$)	For AP use ONLY	
					Exch Rate	CDN Value
<b>Total Converted \$\$</b>						

**Expenses Paid (Retain a copy for your records)**  
 Do not include amounts paid by Alberta Health Services or reimbursed / reimbursable by another organization.

235



**DELTA**

CALGARY SOUTH

135 Southland Drive S.E. Calgary, Alberta, T2J 5X5  
 Tel: 403-278-5050 Fax: 403-225-5834

ALBERTA HEALTH SERVICES  
 Ms Glenda Coleman-Miller  
 Canada

Room: 0274  
 Folio: 122  
 Cashier: 122  
 Arrival: 02-29-12  
 Departure: 03-01-12

Group: ALBERTA HEALTH SERVICES

Date	Description	Additional Information	Charges	Credits
02-29-12	In Room Dining Charges	Line# 274 : CHECK# 0214	26.00	
02-29-12	Room Charge		179.00	
02-29-12	DMF		5.37	
02-29-12	Room GST		9.22	
02-29-12	Tourism Levy		7.37	

GST Summary	
Registration No:	895126332
Room	9.22
F&B	0.00
Other	0.00
<b>Total</b>	<b>9.22</b>

Total	226.96	0.00
Balance Due	226.96	CDN

Guest Signature: \_\_\_\_\_

I agree that my liability for this bill is not waived and I agree to be held personally liable in the event that the indicated person, company, or association fails to pay for any part of or the full amount of these charges.

I have accepted delivery of the Globe and Mail. If refused, a \$1.00 (Mon-Fri) and \$2.00 (Sat) credit will be applied to my account.

APPLICANT COPY

*Statement from  
Holiday Inn - e-file  
sender Glenda?*

**Deidre Rainey**

**From:** Glenda Coleman-Miller  
**Sent:** Sunday, February 12, 2012 8:23 PM  
**To:** Deidre Rainey  
**Cc:** Melissa Waltner  
**Subject:** RE: NEED RESPONSE: RE: Difficult Discharge

*Feb 15/12  
Paper copy  
attached  
GA*

**Categories:** Waiting for Response

Fran and Melissa - can you get me a copy of a statement for this charge - so I can submit for reimbursement? Thanks.

---

**From:** Deidre Rainey  
**Sent:** Monday, January 23, 2012 4:29 PM  
**To:** Glenda Coleman-Miller  
**Cc:** Reverdi Darda  
**Subject:** NEED RESPONSE: RE: Difficult Discharge  
**Importance:** High

Hi Glenda,

As you'll recall, last week we had submitted the paperwork to pay for a difficult discharge to stay at a hotel, we had put on your credit card for 4 nights, which would mean departure from hotel today. The hotel called me to let me know the guest was not leaving because she had a letter from the social worker that stated we would pay for 5 nights, the hotel has sent me the letter and it does state 5 nights. The Medicine PCM said the social work fund would be able to cover one more night. (Social worker that sent the letter is not in today) Are you ok with them charging 1 more night on your credit card?

Let me know, thanks,  
D

---

**Deidre Rainey**  
*Executive Assistant to  
Glenda Coleman-Miller, Vice President  
University of Alberta Hospital  
Mazankowski Alberta Heart Institute  
Edmonton Clinic South*

*1F1.16, Walter C. MacKenzie Centre  
8440 - 112 Street  
Edmonton, AB T6G 2B7*

*Phone: 780.407.8009  
Fax: 780.407.7418*  
**Alberta Health Services**  
[www.albertahealthservices.ca](http://www.albertahealthservices.ca)

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APPLICANT COPY



130

02-15-12

<b>Glenda Coleman-Miller</b> <b>CA DESCRIPTION</b>  s.17(1), 17(4)(g)(i)	Folio No. :	129660	Room No. :	213
	A/R Number :		Arrival :	01-19-12
	Group Code :		Departure :	01-24-12
	Company :	Medical Rate	Conf. No. :	61058716
	Membership No. :		Rate Code :	ILSDQ
	Invoice No. :		Page No. :	1 of 2

Date	Description	Charges	Credits
01-19-12	*Room	127.00	
01-19-12	GST Tax	6.35	
01-19-12	Trsm Levy Tax	5.08	
01-19-12	Municipal DMF Tax	1.27	
01-19-12	Municipal DMF Tax GST	0.06	
01-20-12	*Room	106.00	
01-20-12	GST Tax	5.30	
01-20-12	Trsm Levy Tax	4.24	
01-20-12	Municipal DMF Tax	1.06	
01-20-12	Municipal DMF Tax GST	0.05	
01-21-12	*Room	106.00	
01-21-12	GST Tax	5.30	
01-21-12	Trsm Levy Tax	4.24	
01-21-12	Municipal DMF Tax	1.06	
01-21-12	Municipal DMF Tax GST	0.05	
01-22-12	Long Distance Call	3.20	Line
01-22-12	*Room	127.00	
01-22-12	GST Tax	6.35	
01-22-12	Trsm Levy Tax	5.08	
01-22-12	Municipal DMF Tax	1.27	
01-22-12	Municipal DMF Tax GST	0.06	
01-23-12	*Room	153.00	
01-23-12	GST Tax	7.65	
01-23-12	Trsm Levy Tax	6.12	
01-23-12	Municipal DMF Tax	1.53	

Holiday Inn Express Downtown  
 Edmonton 10010 - 104 Street  
 Canada T5J 0Z1 Edmonton, AB  
 Telephone: (780) 423-2450 Fax: (780) 426-6090  
 0GST #896724515  
 www.hiexdowntown.com



130

02-15-12

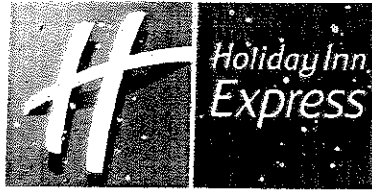
<b>Glenda Coleman-Miller</b> <b>CA DESCRIPTION</b>  s.17(1), 17(4)(g)(i)	Folio No. :	129660	Room No. :	213
	A/R Number :		Arrival :	01-19-12
	Group Code :		Departure :	01-24-12
	Company :	Medical Rate	Conf. No. :	61058716
	Membership No. :		Rate Code :	ILSDQ
	Invoice No. :		Page No. :	2 of 2

Date	Description	Charges	Credits
01-23-12	Municipal DMF Tax GST	0.08	
01-24-12	Visa s.17(1), 17(4)(e.1)		684.40
	<b>Total</b>	<b>684.40</b>	<b>684.40</b>
	<b>Balance</b>	<b>0.00</b>	

**Guest Signature:** \_\_\_\_\_

I have received the goods and / or services in the amount shown heron. I agree that my liability for this bill is not waived and agree to be held personally liable in the event that the indicated person, company, or associate fails to pay for any part or the full amount of these charges. If a credit card charge, I further agree to perform the obligations set forth in the cardholder's agreement with the issuer.

APPLICANT COPY



130

02-15-12

<b>Glenda Coleman-Miller</b> <b>CA DESCRIPTION</b>  s.17(1), 17(4)(g)(i)	Folio No. :	129660	Room No. :	213
	A/R Number :		Arrival :	01-19-12
	Group Code :		Departure :	01-24-12
	Company :	Medical Rate	Conf. No. :	61058716
	Membership No. :		Rate Code :	ILSDQ
	Invoice No. :		Page No. :	1 of 2

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01-22-12	*Room	127.00	
01-22-12	GST Tax	6.35	
01-22-12	Trsm Levy Tax	5.08	
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Holiday Inn Express Downtown  
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 Canada T5J 0Z1 Edmonton, AB  
 Telephone: (780) 423-2450 Fax: (780) 426-6090  
 OGST #896724515  
 www.hiexdowntown.com



*Lynn*

**Deidre Rainey**

---

**From:** Reverdi Darda  
**Sent:** Monday, January 23, 2012 5:35 PM  
**To:** Deidre Rainey; Glenda Coleman-Miller  
**Subject:** RE: NEED RESPONSE: RE: Difficult Discharge

Hi Deidre,  
I have confirmed 1 more night at the Hotel and will follow-up with Carol and Jason first thing in the morning.  
Thanks Rev

---

**Reverdi Darda**

Executive Director  
Zone Medicine Program, Ambulatory Care & RT Services  
Alberta Health Services  
University of Alberta  
8440 112 Street  
Edmonton, AB T6G 2B7

**tel:** 780-407-4690 **fax:** 780-407-8298  
[Reverdi.Darda@albertahealthservices.ca](mailto:Reverdi.Darda@albertahealthservices.ca)

**Alberta Health Services**

[www.albertahealthservices.ca](http://www.albertahealthservices.ca)

*Difficult  
Discharge  
Medicine pt.  
GCM put on  
her creditcard*

---

**From:** Deidre Rainey  
**Sent:** Monday, January 23, 2012 5:09 PM  
**To:** Reverdi Darda; Glenda Coleman-Miller  
**Subject:** RE: NEED RESPONSE: RE: Difficult Discharge  
**Importance:** High

Hi Glenda,  
It turns out there is more to this story, Rev is trying to sort it out now with her PCM/Community. You may still need to approve an extra night but I'll leave it to Rev to advise you.

Rev - I have to run because I have an app't, once this is sorted out can you please call Kent (General Manager) back at the Holiday Inn Express to let him know if we are extending the one night stay or not. He is only in until 5:30, his number is 780-423-2450, if you miss him there will be another 'Guest Manager' on that you can speak with.

Thanks,  
Deidre

---

**From:** Deidre Rainey  
**Sent:** Monday, January 23, 2012 4:29 PM  
**To:** Glenda Coleman-Miller  
**Cc:** Reverdi Darda  
**Subject:** NEED RESPONSE: RE: Difficult Discharge  
**Importance:** High

## APPLICANT COPY

Hi Glenda,

As you'll recall, last week we had submitted the paperwork to pay for a difficult discharge to stay at a hotel, we had put on your credit card for 4 nights, which would mean departure from hotel today. The hotel called me to let me know the guest was not leaving because she had a letter from the social worker that stated we would pay for 5 nights, the hotel has sent me the letter and it does state 5 nights. The Medicine PCM said the social work fund would be able to cover one more night. (Social worker that sent the letter is not in today) Are you ok with them charging 1 more night on your credit card?

Let me know, thanks,

D

---

**Deidre Rainey**

**Executive Assistant to**

*Glenda Coleman-Miller, Vice President*

*University of Alberta Hospital*

*Mazankowski Alberta Heart Institute*

*Edmonton Clinic South*

*1F1.16, Walter C. MacKenzie Centre*

*8440 - 112 Street*

*Edmonton, AB T6G 2B7*

**Phone: 780.407.8009**

**Fax: 780.407.7418**

**Alberta Health Services**

**[www.albertahealthservices.ca](http://www.albertahealthservices.ca)**

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10010 - 104 Street, Edmonton, AB, T5J 0Z1  
Phone: (780) 423-2450 Toll Free: 1-877-423-4656  
Fax: (780) 426 - 6090  
info@hiexedmonton.com  
www.hiexdowntown.com

CREDIT CARD AUTHORIZATION AGREEMENT

I Glenda Coleman-Miller authorize "Holiday Inn Express Downtown" to apply charges to my:

VISA     MASTER CARD     AMERICAN EXPRESS

CREDIT CARD#: \_\_\_\_\_ EXPIRY: \_\_\_\_\_ s.17(1), 17(4)(e.1)

Confirmation Numbers: 61058716

Arrival: Jan 19 2012    Departure: Jan 23, 2012    Rate: \$2 x 127.00 & 2 x 106.00

Guest Names: \_\_\_\_\_ s.17(1), 17(4)(g)(i)

For the accommodations listed below:

- Accommodation, Tax & Security Deposit
  - Banquet & Meeting Room Charges
  - Additional Services
  - Long Distance Charges
  - LogNet, Movies, Games & Music
  - Parking (\$10.00/ Per Night)
- (As arranged and listed below)

All Charges

I agree that my liability for the charges will not be waived and I agree to be held personally liable in the event that the credit card holder of the company or guest fails to pay the full amount of the charges.

I acknowledge that Holiday Inn Express Downtown is a fully NON-SMOKING hotel. Smoking in the guest rooms or balconies will cause \$270.00 extra cleaning fee. (Per Occurrence) If you are a smoker you must come down and go outside.

CREDIT CARD INFORMATION:

Last Name: Coleman-Miller    First Name: Glenda

Phone#: (780) 407-8009    Fax#: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Company Name: Alberta Health Services

Glenda Coleman-Miller    2012-01-19  
Cardholder Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

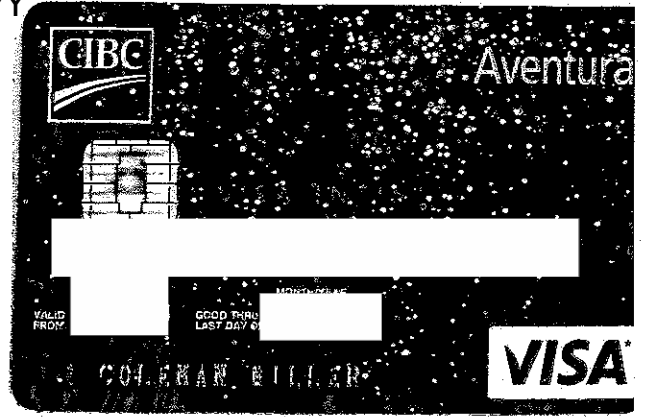
**\*A LEGIBLE PHOTOCOPY OF THE FRONT AND BACK OF THE CREDIT CARD MUST BE ATTACHED TO THE FAX, TO BE CONSIDERED VALID.\***

**THIS AUTHORIZATION FORM WILL NOT BE ACCEPTED IF THE REQUIRED ATTACHMENT (LETTER OR PHOTOCOPY) IS ABSENT.**

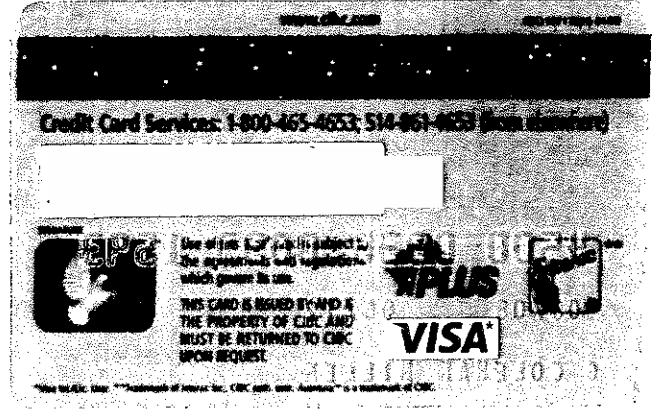
**\*A LEGIBLE PHOTOCOPY OF A CORPORATE CREDIT CARD MAY BE SUBSTITUTED WITH AN AUTHORIZATION LETTER ON COMPANY LETTERHEAD.\***

APPLICANT COPY

s.17(1), 17(4)(e.1)



s.17(1), 17(4)(e.1)



# APPLICANT COPY



10010 - 104 Street, Edmonton, AB, T5J 0Z1  
 Phone: (780) 423-2450 Toll Free: 1-877-423-4656  
 Fax: (780) 426-6090  
 info@hiexedmonton.com  
 www.hiexdowntown.com

## CREDIT CARD AUTHORIZATION AGREEMENT

I Glenda Coleman-Miller authorize "Holiday Inn Express Downtown" to apply charges to my:

- VISA     MASTER CARD     AMERICAN EXPRESS

CREDIT CARD#: \_\_\_\_\_ EXPIRY: \_\_\_\_\_

s.17(1), 17(4)(e.1)

Confirmation Numbers: 61058716

Arrival: Jan 19, 2012    Departure: Jan 23, 2012    Rate: \$2 x 127.00 € 2 x 126.00

Guest Names: \_\_\_\_\_ s.17(1), 17(4)(g)(i)

For the accommodations listed below:

- |   |  |
|---|--|
| <input checked="" type="checkbox"/> Accommodation, Tax & Security Deposit | <input type="checkbox"/> Long Distance Charges         |
| <input type="checkbox"/> Banquet & Meeting Room Charges                   | <input type="checkbox"/> LogNet, Movies, Games & Music |
| <input type="checkbox"/> Additional Services                              | <input type="checkbox"/> Parking (\$10.00/ Per Night)  |
- (As arranged and listed below)

All Charges

I agree that my liability for the charges will not be waived and I agree to be held personally liable in the event that the credit card holder of the company or guest fails to pay the full amount of the charges.

I acknowledge that Holiday Inn Express Downtown is a fully NON-SMOKING hotel. Smoking in the guest rooms or balconies will cause \$270.00 extra cleaning fee. (Per Occurrence) If you are a smoker you must come down and go outside.

### CREDIT CARD INFORMATION:

Last Name: Coleman-Miller    First Name: Glenda

Phone#: (780) 407-8009    Fax#: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Company Name: Alberta Health Services

Glenda Coleman-Miller    2012-01-19  
 Cardholder Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

**\*A LEGIBLE PHOTOCOPY OF THE FRONT AND BACK OF THE CREDIT CARD MUST BE ATTACHED TO THE FAX, TO BE CONSIDERED VALID.\***

**THIS AUTHORIZATION FORM WILL NOT BE ACCEPTED IF THE REQUIRED ATTACHMENT (LETTER OR PHOTOCOPY) IS ABSENT.**

**\*A LEGIBLE PHOTOCOPY OF A CORPORATE CREDIT CARD MAY BE SUBSTITUTED WITH AN AUTHORIZATION LETTER ON COMPANY LETTERHEAD.\***

## TX RESULT REPORT

NAME : UAH SITE ADMINISTRATION  
 TEL : 780 407 7418  
 DATE : JAN.19.2012 16:37

SESSION	FUNCTION	NO.	DESTINATION STATION	DATE	TIME	PAGE	DURATION	MODE	RESULT
1240	TX	001	97804266090	JAN.19	16:36	002	00h00min56s	ECM	OK

APPLICANT COPY



January 19, 2012

To Whom It May Concern at Holiday Inn Express  
RE: s.17(1), 17(4)(g)(i)

s.17(1), 17(4)(g)(i)

This is to confirm that as of January 19, 2012 [redacted] has been discharged from the University of Alberta Hospital. The hospital will be providing funding for [redacted] to stay at the Holiday Inn Express for 5 nights, she will check in January 19, 2012 and will check out January 24, 2012. s.17(1), 17(4)(g)(i)

Should you have any questions or require further information please contact me at (780)407-1320.

Thank you,

*Jason Woywitka BSW, RSW*

Jason Woywitka BSW, RSW  
Social Work  
University of Alberta Hospital

# APPLICANT COPY



10010 - 104 Street, Edmonton, AB, T5J 0Z1  
Phone: (780) 423-2450 Toll Free: 1-877-423-4656  
Fax: (780) 426 - 6090  
info@hiexedmonton.com  
www.hiexdowntown.com

## CREDIT CARD AUTHORIZATION AGREEMENT

I Glenda Coleman-Miller authorize "Holiday Inn Express Downtown" to apply charges to my: s.17(1), 17(4)(e.1)

- VISA
- MASTER CARD
- AMERICAN EXPRESS

CREDIT CARD#: \_\_\_\_\_ EXPIRY: \_\_\_\_\_

Confirmation Numbers: 61058716

Arrival: Jan 19 2012 Departure: Jan 23 2012 Rate: 2x127.00 & 2x106.00

Guest Names: \_\_\_\_\_ s.17(1), 17(4)(g)(i)

For the accommodations listed below:

- Accommodation, Tax & Security Deposit
- Banquet & Meeting Room Charges
- Additional Services (As arranged and listed below)
- Long Distance Charges
- LogNet, Movies, Games & Music
- Parking (\$10.00/ Per Night)

All Charges

I agree that my liability for the charges will not be waived and I agree to be held personally liable in the event that the credit card holder of the company or guest fails to pay the full amount of the charges.

I acknowledge that Holiday Inn Express Downtown is a fully NON-SMOKING hotel. Smoking in the guest rooms or balconies will cause \$270.00 extra cleaning fee. (Per Occurrence) If you are a smoker you must come down and go outside.

### CREDIT CARD INFORMATION:

Last Name: Coleman-Miller First Name: Glenda

Phone#: (780) 407-8009 Fax#: 780-407-7418

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Company Name: Alberta Health Services

Glenda Coleman-Miller Date Signed: 2012-01-19

**\*A LEGIBLE PHOTOCOPY OF THE FRONT AND BACK OF THE CREDIT CARD MUST BE ATTACHED TO THE FAX, TO BE CONSIDERED VALID.\***

**THIS AUTHORIZATION FORM WILL NOT BE ACCEPTED IF THE REQUIRED ATTACHMENT (LETTER OR PHOTOCOPY) IS ABSENT.**

**\*A LEGIBLE PHOTOCOPY OF A CORPORATE CREDIT CARD MAY BE SUBSTITUTED WITH AN AUTHORIZATION LETTER ON COMPANY LETTERHEAD.\***

APPLICANT COPY



**GUEST INFORMATION** s.17(1), 17(4)(g)(i)

CA DESCRIPTION  
 Email Address: *System*

Opt Out:   
 I do not wish to receive communications

**MEMBERSHIP INFORMATION**

Priority Club Enrollment:  Yes  No  
 Smoking Preference: \_\_\_\_\_ Bed Type: \_\_\_\_\_  
 Preferred Language: \_\_\_\_\_

**RESERVATION INFORMATION**

Confirmation No. 61058716 Room Type: Two Queen Beds Non Smoking Room #: *213*  
 Arrival Date: 01-19-12 Rate Code: ILSDQ Arrival Rate: 127.00 CAD  
 Departure Date: 01-23-12 Group: s.17(1), 17(4)(g)(i)  
 Number of Nights: 4 Company: Medical Rate Guest Initials: *X*  
 Number of Guests: 1/0

The following daily rate changes apply during your stay:

01-19-12	127.00 CAD X	1 NIGHTS
01-20-12	106.00 CAD X	2 NIGHTS
01-22-12	127.00 CAD X	1 NIGHTS

**SETTLEMENT INFORMATION** s.17(1), 17(4)(e.1)

Payment Method: Visa

Comments: waiting for cc autho

If any of the above information is incorrect or incomplete, please use the section below.

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State/Prov: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_  
 Email Address: \_\_\_\_\_  
 License Plate #: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_

I acknowledge that Holiday Inn Express Downtown Edmonton is a non-smoking Hotel and that smoking in any area of the Hotel including the balconies is strictly forbidden. Smoking is permitted only in an area 5 meters beyond any building entrance. I further acknowledge that contravention of this is subject to a charge of \$250.00, per occurrence.

Guest initials: *X* s.17(1), 17(4)(g)(i)  
 Signature: *X*  
 I have requested weekday delivery of The Globe and Mail. \_\_\_\_\_  
 \_\_\_\_\_ (Monday to Friday) and \$2.00 (Saturday) will be applied to my account.





# Fax Cover Sheet

University of Alberta Hospital

Medicine  
STN. Walter C. Mackenzie Centre  
8440-112 Street  
Edmonton, Alberta  
Canada T6G 2B7

TO: DIERDRE @AHS

Date: <sup>23<sup>rd</sup></sup> Jan 11/12

Pages: (including cover sheet) 2

FROM

TO: KENT
Name: Esther at Holiday Inn
Fax: 780-426-6090
Phone: 780-423-2450

From: UAH
Susan Waywitta
Fax: 780-407-7602
Phone: 780-407-1320

MESSAGE:

**CONFIDENTIALITY WARNING**

This communication is intended for the sole use of the recipient to which it is addressed and may contain confidential, personal, and/or privileged information.

If you are not the intended recipient of this information, please contact the sender immediately at the phone number listed below. Any other distribution, copying, or disclosure is strictly prohibited.



130

01-24-12

<b>Glenda Coleman-Miller</b> <b>CA DESCRIPTION</b>  s.17(1), 17(4)(g)(i)	Folio No. :	129660	Room No. :	213
	A/R Number :		Arrival :	01-19-12
	Group Code :		Departure :	01-24-12
	Company :	Medical Rate	Conf. No. :	61058716
	Membership No. :		Rate Code :	ILSDQ
	Invoice No. :		Page No. :	2 of 2

Date	Description	Charges	Credits
01-23-12	Municipal DMF Tax GST	0.08	
01-24-12	Visa s.17(1), 17(4)(e.1)		684.40
<b>Total</b>		<b>684.40</b>	<b>684.40</b>
<b>Balance</b>		<b>0.00</b>	

**Guest Signature:** \_\_\_\_\_

I have received the goods and / or services in the amount shown hereon. I agree that my liability for this bill is not waived and agree to be held personally liable in the event that the indicated person, company, or associate fails to pay for any part or the full amount of these charges. If a credit card charge, I further agree to perform the obligations set forth in the cardholder's agreement with the issuer.

Holiday Inn Express Downtown  
 Edmonton 10010 - 104 Street  
 Canada T5J 0Z1 Edmonton, AB  
 Telephone: (780) 423-2450 Fax: (780) 426-6090  
 OGST #896724515  
 www.hiexdowntown.com



130 01-24-12

<b>Glenda Coleman-Miller</b> <b>CA DESCRIPTION</b>  s.17(1), 17(4)(g)(i)	Folio No. :	129660	Room No. :	213
	A/R Number :		Arrival :	01-19-12
	Group Code :		Departure :	01-24-12
	Company :	Medical Rate	Conf. No. :	61058716
	Membership No. :		Rate Code :	ILSDQ
	Invoice No. :		Page No. :	1 of 2

Date	Description	Charges	Credits
01-19-12	*Room	127.00	
01-19-12	GST Tax	6.35	
01-19-12	Trsm Levy Tax	5.08	
01-19-12	Municipal DMF Tax	1.27	
01-19-12	Municipal DMF Tax GST	0.06	
01-20-12	*Room	106.00	
01-20-12	GST Tax	5.30	
01-20-12	Trsm Levy Tax	4.24	
01-20-12	Municipal DMF Tax	1.06	
01-20-12	Municipal DMF Tax GST	0.05	
01-21-12	*Room	108.00	
01-21-12	GST Tax	5.30	
01-21-12	Trsm Levy Tax	4.24	
01-21-12	Municipal DMF Tax	1.06	
01-21-12	Municipal DMF Tax GST	0.05	
01-22-12	Long Distance Call	14:42 Line# 7213 : Dialed# [00:00:11]	3.20
01-22-12	*Room	s.17(1), 17(4)(g)(i)	127.00
01-22-12	GST Tax		6.35
01-22-12	Trsm Levy Tax		5.08
01-22-12	Municipal DMF Tax		1.27
01-22-12	Municipal DMF Tax GST		0.06
01-23-12	*Room		153.00
01-23-12	GST Tax		7.65
01-23-12	Trsm Levy Tax		6.12
01-23-12	Municipal DMF Tax		1.53

Holiday Inn Express Downtown  
 Edmonton10010 - 104 Street  
 Canada T5J 0Z1 Edmonton, AB  
 Telephone: (780) 423-2450 Fax: (780) 426-6090  
 0GST #896724515  
 www.hlexdowntown.com

TOM'S PIZZA & STEAKHOUSE  
10303 101ST AVE  
LAC LA BICHE AB  
S.17(1), 17(4)(e.1)

CARD TYPE: VISA  
CARD: 030688955-001-208-017-0  
DATE: 2012/03/05  
TIME: 0567 13:04:34  
CLERK ID: 03  
RECEIPT NUMBER: 03

PURCHASE AMOUNT: \$61.71  
TIP: \$12.94  
TOTAL: \$74.05

Visa Credit  
A0000000031010  
9EDC6DC9C8614E1A  
0000008000  
3807C093B1185B00

APPROVED  
AUTH# 030040 01-027  
THANK YOU

CARDHOLDER NAME

TOM'S PIZZA & STEAKHOUSE  
LAC LA BICHE AB  
(780) 623-4499  
GST# 871245114

S E R V I C E

server: MARINA  
Guest:

Table #11

GRILL HAM & CHE 9.95  
COFFEE 1.99  
1: BLT 8.95  
1: COFFEE 1.99  
2: CHICKEN FINGERS 11.99  
2: CHICK CAESAR 12.95  
2: MASHED POTATOES 10.95

Total 61.71  
Net Sales 58.77  
Total Tax 2.94

1:01 PM 3/5/2012

THANK YOU!  
PLEASE PAY CASHIER

Valid for 15 Hours  
Standard Parking 107 Street  
Machine Web ID = LOT 107  
EXPIRES  
**02 MAR**  
**17:09** PAID \$ 9.00C  
ENTRY TIME 02 MAR 12 15:39 s.17(1), 17(4)(e.1)  
08855

DASH FACE UP

PLACE ON DASH FACE UP

PLACE ON DASH FACE UP

TABLEAU DU BORD  
CÔTÉ VISIBLE

PLACER SUR LE TABLEAU DU BORD  
CE CÔTÉ VISIBLE

PLACER SUR LE TABLEAU DU B  
CE CÔTÉ VISIBLE

*Calvin... m. Calgary*  
ALLIED LITHO ASSOCIATED  
307 41 AVENUE HE 12E2H4  
CALGARY AB  
21640631

02-29-2012 21:47:03  
ACCT # C  
EXP Date Card Type V1  
MRS. SLENDA COLCATH-MILLER  
ADDRESS 03031010 VISA  
S.17(1), 17(4)(e.1)  
CARD # 130030

FVZ164063176  
ID# # 146  
ADDR # 010662 ERM 00100000  
Purchase \$65.75  
Tip \$6.06  
Total \$71.75

APPLICANT COPY

(00) APPROVED BANK  
Return to City  
1000  
JULY

**SECTION A - Employee Details (for AHS Staff ONLY)**

**TRAVEL, HOSPITALITY & HOSTING EXPENSE CLAIM**

AHS - Edmonton  
Accounts Payable  
MAY 28 2012  
RECEIVED

Travel Period from: 12-Mar-12 to 1-May-12  
 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)

Name: Glenda Coleman-Miller Position (Title): VP, UAHs Employee # (E-People): S.17(1), 17(4)(g)(4) Employee # (Legacy): S.17(1), 17(4)(g)(1)  
 Location: UAH Dept: Site Administration Union: Business Phone # 407-8009 Ext: Out-of-Province Travel: Yes

What is your former legacy region (prior to AHS consolidation)?  
 SECTION E Finance Coding & Total Claim  
 Please click in cell and select from dropdown menu Capital Health

CAPITAL PROJECT CODING ONLY ->  
 Project Number: \_\_\_\_\_ Expenditure Organization: \_\_\_\_\_ Project Task Number: \_\_\_\_\_ 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)	Bal Unit	Location	Functional Centre (FC)	Secondary/Expense	Total Section B	Total Section C&D	
2A	101	0300	71110100064	101	0300	71110100064	66020000	\$633.84	\$423.95	
2B										
2C										
2D										
			Total				Total	\$633.84	\$423.95	
								TOTAL CLAIM		\$1,057.79

\*\*User to enter Coding & \$ amounts  
 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 approval signatures required as well as DOFA level (delegation of authority level) and Position # of the approver.  
 Claim Prepared by (PRINT ONLY) Daidra Rainey Phone # 407-8009 Ext \_\_\_\_\_

I hereby certify that the expenses listed above are in accordance to applicable policies and was incurred on Alberta Health Services business and have not been previously claimed by me or on my behalf from Alberta Health Services or other organization.  
 Employee Signature: *Daidra Rainey* Date: 2012-05-22

I hereby certify that I have reviewed the expenses and they are in accordance with the applicable policies (Policy # CF-03, CF-04).  
 Approved claim form with receipts should be sent by the approver directly to Accounts Payable for processing.  
 Approved By (PRINT ONLY) Mike Conroy DOFA Level: SVP Position # \_\_\_\_\_ Phone # \_\_\_\_\_ Ext \_\_\_\_\_

Signature: *[Signature]* Title: SVP, Edmonton Zone DOFA Level: \_\_\_\_\_ Position # \_\_\_\_\_ Phone # \_\_\_\_\_ Ext \_\_\_\_\_  
 Approved By (PRINT ONLY) \_\_\_\_\_ Title: \_\_\_\_\_ DOFA Level: \_\_\_\_\_ Position # \_\_\_\_\_ Phone # \_\_\_\_\_ Ext \_\_\_\_\_

AHS - Edmonton  
Accounts Payable  
MAY 28 2012  
Q & C - Completed  
Initials: *[Initials]*

Enter Finance Coding 101 • 0300 • 71110100064

Emp # (E-People)

Emp # (Legacy)

If expenses incurred are for multiple FC's please use pages 2B, 2C, 2D (after pg3) as there should be one FC per page OR if more lines are required for the same FC use these additional pages. Enter total \$ amount on slip. **DO NOT separate any taxes (eg GST). Secondary/Expense codes are not required in this section as they are pre-determined by the system.**

**SECTION B Travel Expenses** NOTE: If expenses do not fall into these categories (such as relocation, continuing education, business insurance), go to SECTION C

Select from dropdown menu (column Province) where expenses were incurred (Out of N.America = Inter'l). Ensure separate lines are used for claim items that differ in Province, US and Out of North America.

Date dd-mm-yy	Purpose of Travel 55 characters maximum (length of shaded area)	Province, US, or Out of N.America	What is travel related to?	Meal		Airfare Bus/LRT Parking	Hotel	Rental Car	Taxi	Fuel	Mileage (km)
				(Select type from dropdown) Type	w/receipt per diem						
12-Mar-12	Off Site Meeting					\$14.00					
20-Mar-12	Off Site Meeting					\$14.00					
23-Mar-12	Off Site Meeting					\$7.00					
10-Apr-12	Off Site Meeting					\$10.00					
26-Apr-12	Nursing Leadership Conference - Toronto	ON	Educ	A		\$43.00	\$202.27				
25-Apr-12	Nursing Leadership Conference - Toronto	ON	Educ				\$202.27				
May-12	Airport Parking - Meeting in Calgary						\$21.00				
May-12	Meeting in Calgary								\$65.00		
May-12	Meeting in Calgary								\$55.30		
<b>SUBTOTALS</b>						\$43.00	\$66.00	\$404.54	\$120.30		

**MEAL PER DIEM RATES**  
 B = Breakfast = \$10 L = Lunch = \$12 D = Dinner = \$21 A = ALL MEALS = \$43  
 BL = Breakfast & Lunch = \$22 BD = Breakfast & Dinner = \$31 LD = Lunch & Dinner = \$33

Enter \$0.505 OR rate per Union Agreement

Mileage \$ \_\_\_\_\_  
 Travel \$ Subtotal \$633.94  
 Enter on page 1 TOTAL TRAVEL \$ 633.94

Note, total will auto fill into pg 1, Section E, if form completed electronically - Additional pg 2s can be found at end of form



APPLICANT COPY

Sheraton Gateway Hotel  
 PO Box 3000  
 PO Box 3000  
 Toronto, ON L5P 1C4  
 Canada  
 Tel: 905-672-7000 Fax: 905-672-7100



Ms Glenda Coleman-Miller  
 University Of British Columbia

s.17(1), 17(4)(g)(i)

Email :  
 UBD23A - Univ of British  
 Columbia ( UW

Page Number : 1 Invoice Nbr : 104177  
 Guest Number : 1424087  
 Folio ID : EX-A  
 Arrive Date : 26-APR-12 08:23  
 Depart Date : 27-APR-12  
 No. Of Guest : 1  
 Room Number : 368  
 Room Rate : 179.00  
 Club Account :

s.17(1), 17(4)(g)(i)

Information Invoice

Tax ID : 140047879  
 Sheraton Gateway 27-APR-12 03:14 FLORCHA

Date	Reference	Description	Charges	Credits
			Non-Responsive	
26-APR-12			(74.67)	
26-APR-12	RT368	Room Charge Group	179.00	
26-APR-12	RT368	Rooms HST	23.27	
		** Total	276.94	0.00
		*** Balance	276.94	

*just put in per diem 43.00*

*245.27*

HST Summary for your stay:	Amount CAD
Room Revenue HST	23.27
Food & Beverage HST	7.67
Photo/Fax/Copy Services HST	0.00
Other Revenue HST	0.00
Total HST for your stay:	30.94

*= \$ 202.27*

Continued on the next page



APPLICANT COPY

Sheraton Gateway Hotel  
 PO Box 3000  
 PO Box 3000  
 Toronto, ON L5P 1C4  
 Canada  
 Tel: 905-672-7000 Fax: 905-672-7100



s.17(1), 17(4)(g)(i)  
 Ms Glenda Coleman-Miller  
 University Of British Columbia

Page Number : 2 Invoice Nbr : 104177  
 Guest Number : 1424087  
 Folio ID : EX-A  
 Arrive Date : 26-APR-12 08:23  
 Depart Date : 27-APR-12  
 No. Of Guest : 1  
 Room Number : 368  
 Room Rate : 179.00  
 Club Account :

Email :  
 UBD23A - Univ of British  
 Columbia ( UW

s.17(1), 17(4)(g)(i)

Information Invoice

Turn stays into getaways. As a Starwood Preferred Guest member you will earn Starpoints for your stays, then use those points on anything from free nights and free flights without blackout dates to merchandise and once-in-a-lifetime experiences. If you're not already a member, join at the front desk or at [www.SPG.com](http://www.SPG.com)

As a Starwood Preferred Guest you have earned at least 523 Starpoints for this visit

s.17(1), 17(4)(g)(i)

EXPENSE SUMMARY REPORT

Date	Room	Food/Bev	Phone	Taxes	Other	Total
26-APR-12	179.00	67.00	0.00	30.94	0.00	276.94
Total	179.00	67.00	0.00	30.94	0.00	276.94

Date	Payment
26-APR-12	0.00
Total	0.00

APPLICANT COPY

Sheraton Gateway Hotel  
 PO Box 3000  
 PO Box 3000  
 Toronto, ON L5P 1C4  
 Canada  
 Tel: 905-672-7000 Fax: 905-672-7100  
 s.17(1), 17(4)(g)(i)  
 Ms Glenda Coleman-Miller\*



Page Number : 1 Invoice Nbr : 103947  
 Guest Number : 1420622  
 Folio ID : EX-A  
 Arrive Date : 25-APR-12 01:47  
 Depart Date : 26-APR-12  
 No. Of Guest : 1  
 Room Number : 368  
 Room Rate : 179.00  
 Club Account :

s.17(1), 17(4)(g)(i)

Email :  
 UWB18A - Univ of Western  
 ON (UWO) & UBC

Information Invoice

Tax ID : 140047879  
 Sheraton Gateway 26-APR-12 02:59 FLORCHA

Date	Reference	Description	Charges	Credits
25-APR-12	RT368	Room Charge Group	179.00	
25-APR-12	RT368	Rooms HST	23.27	
		** Total	202.27	0.00
		*** Balance	202.27	

HST Summary for your stay:	Amount CAD
Room Revenue HST	23.27
Food & Beverage HST	0.00
Photo/Fax/Copy Services HST	0.00
Other Revenue HST	0.00
Total HST for your stay:	23.27

Continued on the next page

APPLICANT COPY

Sheraton Gateway Hotel  
 PO Box 3000  
 PO Box 3000  
 Toronto, ON L5P 1C4  
 Canada  
 Tel: 905-672-7000 Fax: 905-672-7100



s.17(1), 17(4)(g)(i)  
 Ms Glenda Coleman-Miller\*

Page Number : 2 Invoice Nbr : 103947  
 Guest Number : 1420622  
 Folio ID : EX-A  
 Arrive Date : 25-APR-12 01:47  
 Depart Date : 26-APR-12  
 No. Of Guest : 1  
 Room Number : 368  
 Room Rate : 179.00  
 Club Account :

Email :  
 UWB18A - Univ of Western  
 ON (UWO) & UBC

s.17(1), 17(4)(g)(i)

Information Invoice

Stay Connected with the Link@Sheraton experienced with Microsoft. Join us at the Link, our lobby connectivity hub where guests meet, connect and relax. Whether you're surfing the Web, watching a game with friends, borrowing a newspaper or printing a boarding pass, out of town doesn't mean out of touch. Learn more at [www.sheraton.com/link](http://www.sheraton.com/link)

As a Starwood Preferred Guest you have earned at least 393 Starpoints for this visit

s.17(1), 17(4)(g)(i)

EXPENSE SUMMARY REPORT

Date	Room	Food/Bev	Phone	Taxes	Other	Total
25-APR-12	179.00	0.00	0.00	23.27	0.00	202.27
<b>Total</b>	<b>179.00</b>	<b>0.00</b>	<b>0.00</b>	<b>23.27</b>	<b>0.00</b>	<b>202.27</b>

Date	Payment
25-APR-12	0.00
<b>Total</b>	<b>0.00</b>

YOUR  
STAY

YOUR  
way

Was our service delivery  
up to your expectations?

Exceeded expectations

Room for improvement



**Sheraton  
Gateway**  
HOTEL IN TORONTO  
INTERNATIONAL AIRPORT

We welcome your feedback!

---

---

---

---

---

---

---

---

---

---

Guest Name \_\_\_\_\_

Room # \_\_\_\_\_



\_\_\_\_\_

Are you a Starwood Preferred Guest?

YES

NO

We will be happy to enrol you. Membership is free

Start enjoying all the benefits in any of our 1000+ hotels worldwide

Please ask one of our Front desk associates or provide your e-mail address

and we will forward your Starwood Preferred Guest account number

Please drop completed form at the front desk

APPLICANT COPY

GCM Expense

Please print and bring this ticket

Event

# ACEN Membership 2011-2013



81507417103712881001



Date+Time

Wednesday, 14 March 2012 at 9:00 AM - T

12:00 PM (PT)

Type

Membership 2011-2013

12:05

Name

Glenda Coleman-Miller

Payment Status

Eventbrite Completed

Location



Order Info

Ordered by Glenda Coleman-Miller on 15

PM

Please PRINT and bring this ticket to the event entrance.



07417103712881001



**Do you organize events?**

Start selling in minutes with Eventbrite!

[www.eventbrite.ca](http://www.eventbrite.ca)

APPLICANT COPY

ROYAL ALEXANDRA HOSPITAL  
50 PARKADE - PUBLIC PARKING

GST # R124072613

03/23/12 11:59 AM 1400 10 1400 25000  
03/23/12 10:10 In 03/23/12 11:59 Out  
TRIP 200017

Hourly Fee \$ 7.00  
Total Fee \$ 7.00  
Cash Paid \$ 7.00-  
Cash Tender \$ 7.00  
Change Due \$ 0.00

GST Included in Price

Comments - email us :  
m.vinciguerra@kungs  
other@shred.com/vervaldes@u

DISPLAY THIS SIDE UP ON DASHBOARD

DETACH RECEIPT FROM TICKET

EXPIRATION DATE 20/03/12 EXPIRATION TIME 06:00 AM  
DATE ISSUED 19/03/12 TIME ISSUED 11:58 AM AMOUNT PAID \$ 14.00

AMOUNT PAID \$ 14.00 848800000 11:58 AM

CREDIT CARD NUMBER LOT M



UNIVERSITY OF ALBERTA



UNIVERSITY OF ALBERTA

0585312

NON TRANSFERABLE

0585312

RECEIPT GST# R108102831

DISPLAY THIS SIDE UP ON DASHBOARD

DETACH RECEIPT FROM TICKET

EXPIRATION DATE 13/03/12 EXPIRATION TIME 06:00 AM  
DATE ISSUED 12/03/12 TIME ISSUED 11:38 AM AMOUNT PAID \$ 14.00

AMOUNT PAID \$ 14.00 848800000 11:38 AM

CREDIT CARD NUMBER LOT M



UNIVERSITY OF ALBERTA



UNIVERSITY OF ALBERTA

0585023

NON TRANSFERABLE

0585023

RECEIPT GST# R108102831

*Parking @ Macleay Park  
Prattley Lane  
Breakfast*

1246810 07:58 000 001  
1246810 07:12  
RATE 1  
TOTAL \$10.00  
CASH \$10.00

FOR MONTHLY PARKING  
PHONE 877094199  
GST INCLUDED

*Don't forget to  
bring in Calgary Airport  
Tax Code CA5%*

Can - T53 2T2 Edmonton  
Tax Code CA5%  
POF 1st F1 01/05/12 17:48  
Receipt 020204  
Short-term parking tkt  
DL - No. S.17(1), 17(4)(e.1)  
01/05/12 05:58  
02/05/12 05:57  
Period 1d0h0  
(Tax) \$21.00

Total \$21.00  
Payment Received \$21.00

Merch: 82005340013 s.17(1), 17(4)(e.1)  
Auth: 005094  
Type: Swiped  
Sub Total \$20.00  
Tax 5% 1.00

APPLICANT COPY

ASSOCIATED CAB ALTA LTD  
 387 - 41 AVE NE (403) 299-1111  
 INSIST ON THE PROFESSIONALS

DATE: 2012/05/01  
 PICK-UP TIME: 07:55  
 DROP-OFF TIME: 08:30  
 TRIP ID: B  
 LOCATION: 073000-45024103707  
 CAR NUMBER: 1034  
 CARD TYPE: VISA S  
 CARD: \*\*/\*\*  
 EXPIRY: AP813828  
 AUTH: s.17(1), 17(4)(e.1)  
 FARE (\$): 65.00  
 EXTRA (\$): 0.00  
 SUBTTL (\$): 65.00

TIP (\$): \_\_\_\_\_

TOTAL (\$): \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

*Colony Cab*  
*Submanout*  
 FOR ONLINE TAXI BOOKINGS VISIT  
 OUR WEBSITE@WWW.ASSOCIATEDCAB.CA

CUSTOMER'S COPY

= TRANSACTION RECEIPT =

Checker/Yellow Cabs  
 316 Meridian Road SE  
 Calgary, AB T2A 1X2  
 403 299-9999

ACCT TYPE: CREDIT CARD  
 CARD NUMBER: \_\_\_\_\_

s.17(1), 17(4)(e.1)

CARD TYPE: VISA  
 DATE/TIME: 12/05/01 15:39:05  
 AUTH#: 079031

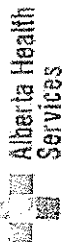
VEH/DRV: 0998 3136  
 GST#: 01299 04  
 TXN ID: 7161673

FARE: \$ 45.52  
 FLAT: \$000.00  
 EXTRAS: \$000.00  
 GST: \$ 2.28

LAF+L+EX+TAX: \$ 47.80  
 TIP: \$ 7.50  
 DISCOUNT: \$000.00

TOTAL: \$ 55.30

SIGNATURE: \_\_\_\_\_  
*Colony Cab*  
*to deposit*



**TRAVEL, HOSPITALITY & HOSTING EXPENSE CLAIM**

**SECTION A - Employee Details (for AHS Staff ONLY)** Travel Period from: 16-May-12 to 18-May-12

- 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)

s.17(1), 17(4)(g)(i) s.17(1), 17(4)(g)(i)

Name Glenda Coleman-Miller Position (Title) VP, UAHs Employee # (E-People) \_\_\_\_\_

Location UAH Dept. Site Administration Union \_\_\_\_\_ Business Phone # 407-8009 Ext \_\_\_\_\_ Out-of-Province Travel Yes

What is your former legacy region (prior to AHS consolidation)? Capital Health

**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**

Pg	Bal Unit	Location	Functional Centre (FC)	Total
2A	101	0300	71110100064	\$90.00
2B				
2C				
2D				
				\$90.00

**Total - Section C&D - Other & Foreign Expenses - Pg 3**

Bal Unit	Location	Functional Centre (FC)	Secondary Expense	Total
101	0300	71110100064	62014601	350.55
				\$350.55

**TOTAL REIMBURSEMENT**

Total Section B	\$90.00
Total Section C&D	\$350.55
Less Cash Advance	
<b>TOTAL CLAIM</b>	<b>\$440.55</b>

\*\*User to enter Coding & \$ amounts

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 approval signatures required as well as DOFA level (delegation of authority level) and Position # of the approver.

Claim Prepared by (PRINT ONLY) Deidre Rainey Phone # 407-8009 Ext \_\_\_\_\_

I hereby certify that the expenses listed above are in accordance to applicable policies and was incurred on Alberta Health Services business and have not been previously claimed by me or on my behalf from Alberta Health Services or other organization.

Employee Signature [Signature] Date June 4/12

I hereby certify that I have reviewed the expenses and they are in accordance with the applicable policies (Policy #'s CF-03, CF-04).

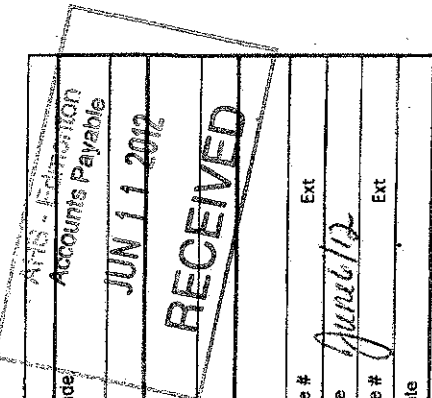
Approved claim form with receipts should be sent by the approver directly to Accounts Payable for processing.

Approved By (PRINT ONLY) Mike Conroy Position # A0202767 Phone # \_\_\_\_\_ Ext \_\_\_\_\_

Signature \_\_\_\_\_ Title SVP, Edmonton Zone Date June 12

Approved By (PRINT ONLY) \_\_\_\_\_ Position # \_\_\_\_\_ Phone # \_\_\_\_\_ Ext \_\_\_\_\_

Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_










**PRESTIGE CABS** 10135 - 31 Avenue  
Edmonton, Alberta T6N 1C2  
ADMIN. 465-8500 FAX: 462-2722 **462-4444**  
THANK YOU/MERCI


Date: May Amount/Montant \$ 45.00 Car/Voiture # 9949  
Driver/Chauffeur: Bryan G.S.T. # 135153104  
From/De: airport To/A: \_\_\_\_\_



PLEASE CALL AGAIN  
AU PLAISER DE VOUS REVOIR

**YELLOW CAB** 780-462-3456

GST# \_\_\_\_\_ GST #R100403070  
Date: May 10 Amount: 45.00  
Driver: [Signature] Car #: \_\_\_\_\_  
From: \_\_\_\_\_  
To: airport

 10135 - 31 Avenue, Edmonton, AB T6N 1C2

707 COLEMANMILLER/GLEND- 139.00 05/18/12 07:24 17885 17330  
Room Name Rate Depart Time ACCT# GROUP  
 NSQN  
Type 05/16/12 20:38  
Arrive Time

50 10030 107TH STREET

PASSPORT:  
VSXXXXXXXXXXXXXXXXXXXX

ALBERTA CA 55902  
Room Clerk Address Payment

MRW#:

DATE	REFERENCE	CHARGES	CREDITS	BALANCE DUE
05/16	ROOM	707, 1	139.00	
05/16	STATETAX	707, 1	15.81	
05/17	VINO	00044176	16.87	<i>Breakfast</i>
05/17	ROOM	707, 1	139.00	
05/17	STATETAX	707, 1	15.81	
05/18	VINO	00044329	16.85	<i>Breakfast</i>
05/18	CCARD-VS		343.34	
SETTLED TO:		VISA	XXXXXXXXXXXXXXXXXXXX	

.00

WANT YOUR FINAL HOTEL BILL BY EMAIL? JUST ASK THE FRONT DESK!  
 SEE "INTERNET PRIVACY STATEMENT" ON MARRIOTT.COM

This statement is your only receipt. You have agreed to pay in cash or by approved personal check or to authorize us to charge your credit card for all amounts charged to you. The amount shown in the credits column opposite any credit card entry in the reference column above will be charged to the credit card number set forth above. (The credit card company will bill in the usual manner.) If for any reason the credit card company does not make payment on this account, you will owe us such amount. If you are direct billed, in the event payment is not made within 25 days after checkout, you will owe us interest from the checkout date on any unpaid amount at the rate of 1.5% per month (Annual Rate 18%), or the maximum allowed by law, plus the reasonable cost of collection, including attorney fees.

Signature X \_\_\_\_\_

AHS - Edmonton  
Accounts Payable  
SEP 13 2012  
C & Q - Completed  
Initials

**TRAVEL, HOSPITALITY & HOSTING EXPENSE CLAIM**

**SECTION A - Employee Details (for AHS Staff ONLY)**

Travel Period from: 13-Apr-12 to 11-Jul-12

Name: Glenda Coleman-Miller  
Position (Title): VP, UAHs  
Employee # (E-People): S.17(1), 17(4)(g)(i)

Location: UAH  
Dept: Site Administration  
Business Phone # 407-8008  
Employee # (Legacy):

Out-of-Province Travel: Yes  
Capital Health:

What is your former legacy region (prior to AHS consolidation)?

SECTION E Finance Coding & Total Claim

**CAPITAL PROJECT CODING ONLY**

Total - Section B - Travel - Pg 2		Total - Section C&D - Other & Foreign Expenses - Pg 3	
Pg	Location	Bal Unit	Location
2A	0300	7110100064	1141.18
2B			
2C			
2D			
Total		1141.18	

**SECTION F Authorization**

Employee Signature: *Glenda Coleman-Miller* Date: *Sept 4/12*

Approved By (PRINT ONLY): Mike Conroy  
Signature: *[Signature]* Title: SVP, Edmonton Zone  
Phone # 407-8009 Ext: 302767

Approved By (PRINT ONLY): Deldre Rainey  
Signature: *[Signature]* Title: SVP, Edmonton Zone  
Phone # 407-8009 Ext: 302767

Approved By (PRINT ONLY): Mike Conroy  
Signature: *[Signature]* Title: SVP, Edmonton Zone  
Phone # 407-8009 Ext: 302767

Approved By (PRINT ONLY): Mike Conroy  
Signature: *[Signature]* Title: SVP, Edmonton Zone  
Phone # 407-8009 Ext: 302767

TOTAL REIMBURSEMENT	
Total Section B	1141.18
Total Section C&D	
Less Cash Advance	
TOTAL CLAIM	1141.18

AHS - Edmonton  
Accounts Payable  
SEP 11 2012  
RECEIVED

s.17(1), 17(4)(g)(i) s.17(1), 17(4)(g)(i)

**EXPENSE CLAIM DETAILS**

**Enter Finance Coding** 101 • 0300 • 71110100064 **Emp # (E-People)** **Emp # (Legacy)** **Page 2A**

If expenses incurred are for multiple FC's please use pages 2B,2C,2D (after pg3) as there should be one FC per page OR if more lines are required for the same FC use these additional pages. Enter total \$ amount on slip. **DO NOT separate any taxes (eg. GST).** Secondary/Expense codes are not required in this section as they are pre-determined by the system.

**SECTION B Travel Expenses**

**NOTE: If expenses do not fall into these categories (such as relocation, continuing education, business insurance), go to SECTION C**

Select from dropdown menu (column Province) where expenses were incurred (Out of N.America = Inter\*). Ensure separate lines are used for claim items that differ in Province, US and Out of North America.

Date dd-mm-yy	Purpose of Travel 55 characters maximum (length of shaded area)	Province, US, or Out of N.America	What is travel related to?	Meal (Select type from dropdown)		Airfare Bus/LRT Parking	Hotel	Rental Car	Taxi	Fuel	Mileage (km)
				Type	w/receipt w/o receipt or per diem						
13-Apr-12	Parking at Airport - Winning for Gamma Knifs Tour	AB	Project			\$21.00 ✓					
17-Apr-12	Parking at Edm Economic Development Luncheon	AB	Meeting			\$12.50 ✓					
25-Apr-12	Taxi to Airport - Nursing Leadership	AB	Educ			<del>\$60.00</del> ✓			60.00		
12-Jun-12	Parking at Provincial Senior Leadership	AB	Meeting			\$15.00 ✓					
14-Jun-12	Parking at Finance Meeting - Matrix Hotel	AB	Meeting			\$10.00 ✓					
16-Jun-12	Parking at Physician Recruitment Planning session	AB	Meeting			\$14.00 ✓					
17-Jun-12	Taxi to Airport - CNA Annual Meeting - Vancouver	BC	Educ			<del>\$60.00</del> ✓			60.00		
17-Jun-12	Taxi to Hotel - CNA Annual Meeting - Vancouver	BC	Educ			<del>\$60.00</del> ✓			60.00		
20-Jun-12	CNA Annual Meeting & Biennial Convention - Vancouver	BC	Educ			<del>\$60.00</del> ✓			60.00		
20-Jun-12	Taxi to Airport - CNA Annual Meeting - Vancouver	BC	Educ			<del>\$40.00</del> ✓			40.00		
20-Jun-12	Taxi from Airport - CNA Annual Meeting - Vancouver	BC	Educ			<del>\$50.00</del> ✓			50.00		
11-Jul-12	NARP Meeting in Red Deer - Parking	AB	Meeting			\$4.50 ✓					
11-Jul-12	NARP Meeting in Red Deer - Dr. Jhndai, Deanna, Glenda	AB	Meeting	B	\$10.17 ✓						
11-Jul-12	NARP Meeting in Red Deer	AB	Meeting								
<b>SUBTOTALS</b>											
											\$10.17
											\$77.00
											\$347.00
											\$270.00
											632.51
											300.00
											\$0.505
											\$151.50
											929.68
											1141.18

Enter \$0.505 OR rate per Union Agreement  
Mileage \$  
Travel \$ Subtotal

Enter on page 1 TOTAL TRAVEL \$

Note, total will auto fill into pg 1, Section E, if form completed electronically - Additional pg 2s can be found at end of form

**MEAL PER DIEM RATES**  
B = Breakfast = \$10 L = Lunch = \$12 D = Dinner = \$21 A = ALL MEALS = \$43  
BL = Breakfast & Lunch = \$22 BD = Breakfast & Dinner = \$31 LD = Lunch & Dinner = \$33





1180 West Hastings Street  
 Vancouver, BC V6E 4R5  
 Tel: (604) 697-0202 Fax: (604) 697-0123

**Mrs Glenda Coleman-Miller**

s.17(1), 17(4)(g)(i)

**Invoice**

Invoice date 6/20/2012  
 Invoice number 69683  
 Our reference CCC-FC89064 /A  
 HST Number 101035467 RT0022

Guest **Mrs Glenda Coleman-Miller** Arrival **6/17/2012** Departure **6/20/2012** Room **0914**

Date	Description	Quantity	Unit Price	Total (CAD)
6/17/2012		2	0.00	31.00
6/17/2012	Non-Responsive	1	3.72	3.72
6/17/2012		1	6.00	6.00
6/17/2012	Room Charge	1	179.00	179.00
6/17/2012	Municipal Room Tax	1	3.58	3.58
6/17/2012	Harmonized Sales Tax Room	1	21.91	21.91
6/18/2012	Room Service Breakfast 7243	1	3.00	3.00
6/18/2012	Room Service Breakfast 7243	1	14.00	14.00
6/18/2012	Non-Responsive	1	3.00	3.00
6/18/2012	Harmonized Sales Tax Other 7243	1	2.04	2.04
6/18/2012	Non-Responsive	1	2.00	2.00
6/18/2012	Room Charge	1	179.00	179.00
6/18/2012	Municipal Room Tax	1	3.58	3.58
6/18/2012	Harmonized Sales Tax Room	1	21.91	21.91
6/19/2012	Room Charge	1	179.00	179.00
6/19/2012	Municipal Room Tax	1	3.58	3.58
6/19/2012	Harmonized Sales Tax Room	1	21.91	21.91

not including

not including

not including

6/20/2012 VS Auth: 096247  
 s.17(1), 17(4)(e.1)

**Total invoice 678.23**  
~~678.23~~

**632.51**

Subtotal 678.23

For reservations: [www.coasthotels.com](http://www.coasthotels.com) or 1-800-663-1144



Mrs Glenda Coleman-Miller

APPLICANT COPY

s.17(1), 17(4)(g)(i)

**Invoice**

Invoice date 6/20/2012  
Invoice number 69683  
Our reference CCC-FC89064 /A  
HST Number 101035467 RT0022

Date	Description	Quantity	Unit Price	Total (CAD)
			Total Paid	-678.23
			Total Due	0.00
Total HST	71.49			

I agree that my liability for any charges incurred by me is not waived and agree to be held personally liable in the event that the indicated person, company or association fails to pay for any part of the full amount of these charges. Interest will be charged on any overdue balance.

Signature X \_\_\_\_\_

For reservations: [www.coasthotels.com](http://www.coasthotels.com) or 1-800-663-1144

Red Deer  
WARP Meeting

# Tim Hortons

Your Friends at Restaurant 2705  
100-4217 50th Ave, Red Deer  
Managers: Margaret, Terry

- 1 Small Coffee \$1.32
- 1 Milk \$0.00
- 1 Sugar \$0.00
- 1 Small Coffee \$1.32
- 1 Milk \$0.00
- 1 Sugar \$0.00
- 1 Bottle Water \$1.40
- 1 Deposit \$0.10
- 1 Bgl-12 Grain \$1.15
- 1 Toasted \$0.00
- 1 Plain Cracks \$0.70
- 1 Sesame \$1.15
- 1 Toasted \$0.00
- 1 Plain Cracks \$0.70
- 1 Bgl-Cinnamon \$1.15
- 1 Toasted \$0.00
- 1 Plain Cracks \$0.70
- Subtotal: \$9.69
- BST: \$0.48
- GrandTotal: \$10.17
- CASH: \$20.00
- Change Due: \$9.83
- Drive Thru # 182 300 Cashier

It was great seeing you today! Thanks for your visit!

How did we do?

Visit [www.timhortons.com](http://www.timhortons.com)  
Wed Jul 11, 2012 12:31:43  
Receipt #: 272037  
GST #846710473

Guest Copy

REPRINT RECEIPT

Edmonton Airports

Can-T5J 2T2 Edmonton  
Tax Code CA5%

PCF 1st F1 13/04/12 20:12  
Receipt 025203

Short-term parking TKT

DL - No. 13/04/12 07:15  
14/04/12 07:14  
Period 1d0h0  
Clax)

Total \$21.00  
Payment Received \$21.00  
VISA

MERCH: 82005340013  
Auth: 044069  
Type: Swiped

S.17(1), 17(4)(e.1)  
Sub Total \$20.00  
Tax 1.00

IMPARK  
PHONE 780-221-1576  
HOURLY PARKER  
METER 101-0001

Time: 7:31A JUN 14

IMPARK  
PHONE 780-221-1576  
HOURLY PARKER  
METER 101-0001

CANADA PLACE PARKADE  
OPERATED BY IMPARK PARKING  
FOR THE CITY OF EDMONTON

S.17(1), 17(4)(g)(i)

Regular Rate \$ 11.50  
Total Tax \$ 0.60  
Total Fee \$ 12.50  
CASH PAID \$ 12.50  
Cash Tender \$ 20.00  
Change Due \$ 7.50  
THANK YOU  
WE APPRECIATE YOUR BUSINESS  
COME AGAIN

s.17(1), 17(4)(e.1)

PLACE FACE UP ON DASH  
Impark Lot 161  
Expiration Date/Time  
EXP 06:00AM  
JUN 13, 2012

Purchase Date/Time: 08:40am Jun 12, 2012  
Total Parking: \$14.28  
Total gst: \$0.72  
Total Due: \$15.00  
Total Paid: \$15.00  
Payment Type: Card  
Auth #: 0103515

SIN #: 100908460006  
Setting: Lot 161  
Mach Name: Meter 1  
GST #887315638RT0001

## APPLICANT COPY

RECEIPT  
Impark Lot 161

Expiration Date/Time: 06:00am Jun 13, 2012  
Purchase Date/Time: 08:40am Jun 12, 2012

Total Parking: \$14.28  
Total gst: \$0.72  
Total Due: \$15.00  
Total Paid: \$15.00  
Payment Type: Card  
Auth #: 0103515

SIN #: 100908460006  
Setting: Lot 161  
Mach Name: Meter 1  
GST #887315638RT0001

s.17(1), 17(4)(e.1)

DISPLAY THIS SIDE UP ON DASHBOARD  
APPLICANT COPY

DETACH RECEIPT FROM TICKET

EXPIRATION DATE: 16/06/12 06:00 AM  
EXPIRATION TIME

DATE ISSUED: 15/06/12 07:15 AM  
TIME ISSUED AMOUNT PAID \$14.00

AMOUNT PAID \$14.00 848800000 07:15 AM

CREDIT CARD NUMBER LOT M



UNIVERSITY OF ALBERTA



UNIVERSITY OF ALBERTA

0717298

NON TRANSFERABLE

0717298

RECEIPT GST # R1081028

780-462-4444

780-462-4444

PRESTIGE CABS

PRESTIGE CABS

GST# 135153104

GST# 135153104

Date: June 17/12 Amount: 60.00

Date: April 25/12 Amount: 60.00

Driver: Bryan Car #: 9949

Driver: Bryan Car #: 9949

From: s.17(1), 17(4)(g)(i)

From:

To: INTERNATIONAL AIRPORT

To:

10135 - 31 Avenue, Edmonton, AB T6N 1C2

10135 - 31 Avenue, Edmonton, AB T6N 1C2

TOTAL 60.00

AMOUNT: 43.00  
HST: 5.16  
TIP: 11.84  
SUBTOTAL 60.00

Payment CASH

DATE: 17-06-2012  
TIME: 20:04  
VEHICLE: 20  
DRIVER#: 50580  
JOB #: 2195470646

Oper: by Highend Limousine

aerocar service

CUSTOMER'S COPY

Thanks for your business!  
GST# 85695 1789 R10001  
www.aerocar-service.ca

604.298.1000  
1.888.821.0021

BLACK TOP AND CHECKER CAB  
604-731-1111

DATE: 2012/06/20  
PICK-UP TIME: 14:48  
DROP-OFF TIME: 15:14  
TRIP ID: 16866  
LOCATION: 073000-45024179754  
CAR NUMBER: 8842  
CARD TYPE: VISA S  
CARD: AP924832  
EXPIRY: A9924832  
AUTH: s.17(1), 17(4)(e.1)

FARE (\$): 40.00  
EXTRA (\$): 0.00  
SUBTTL (\$): 40.00

TIP (\$):

TOTAL (\$):

SIGNATURE:

BLACK TOP AND CHECKER CAB  
604-731-1111

DUPLICATE - DRIVER'S COPY

PRESTIGE CABS

10135 - 31 Avenue  
Edmonton, Alberta T6N 1C2

462-4444

ADMIN. 465-8500  
FAX: 462-2722

THANK YOU/MERCI

Date: June 20/12 Amount/Montant \$ 20.00 Car/Voiture # 9949

Driver/Chauffeur: Bryan G.S.T. # 135153104

From/De: To/A:



PLEASE CALL AGAIN  
AU PLAISIR DE VOUS REVOIR



# APPLICANT COPY

## Payment Requisition

Accounting Services  
10<sup>th</sup> Floor, North Tower CHC  
10030-107 St.  
Edmonton, Alberta T5J 3E4

**I PAYEE INFORMATION** (Check one only)  Vendor   Employee (EE number )

Invoice Date **23-Dec-05** (DD-MMM-YY) Invoice Number \_\_\_\_\_  
Vendor Number (or S.I.N.) \_\_\_\_\_ Payee Name **Glenda Coleman-Milner**  
Address **s.17(1), 17(4)(g)(i)**  
Province/State \_\_\_\_\_ Postal Code \_\_\_\_\_

Employee (EE number )

**s.17(1), 17(4)(g)(i)**

City \_\_\_\_\_  
Country \_\_\_\_\_

**II PAYMENT DETAILS**

Reason for payment **Mileage & Parking - November - December, 2005** (68.5)

Is this a contract payment?  Yes (Attach copy of contract if \_\_\_\_\_)  
If this is a contract payment, what is the contract date? \_\_\_\_\_

Have goods / services been received?  Yes, When? \_\_\_\_\_

Are original attachments to be mailed with cheque? (Note 2)  Yes

PO # \_\_\_\_\_

Number \_\_\_\_\_

No

**III EXPENSE CODES (IN ORACLE FINANCIAL SYSTEM FORMAT)**

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	
201	0002	71110101001	624100	\$2.00
201	0002	71110101001	624100	21.00
<b>Capital Health RECEIVED</b>				
<b>JAN 03 2006</b>				
<b>ACCOUNTS PAYABLE</b>				
<input checked="" type="checkbox"/> Canadian	<input type="checkbox"/> U.S.	<input type="checkbox"/> Other	<b>TOTAL</b>	<b>\$44.97</b>

Attachments must provide Complete Coding)

	GST if applicable	Total Payment
		<b>23.97</b>
		<b>21.00</b>
		<b>\$44.97</b>

**IV AUTHORIZATION**

I confirm that the above items have not been previously paid and the expenses are only to Capital Health business.

Requisitioned by (Print name) **Aileen Savage**  
(Signature) *Aileen Savage*

Approved by (Print name) **Glenda Coleman-Milner**  
(Signature) *Glenda Coleman-Milner*

Approved by (Print name) **Joanna Pawlyshyn**  
(Signature) *Joanna Pawlyshyn*

only to Capital Health business.

Phone # **735-5272**  
Date **23-Dec-05**

Phone # **735-5272**  
Date **23-Dec-05**

Phone # **735-4101**  
Date \_\_\_\_\_

**AUTHORIZATIONS SHOULD BE IN ACCORDANCE WITH SIGNING AUTHORITY**

- Notes:
- All employee payments will be made electronically based on payroll banking information.
  - All cheques and attachments will be mailed out by Accounting Services. Cheques will NOT be cashed.
  - Fully completed payment requisitions received in Accounting Services by **MONDAY, 4:00 p.m.**
  - Incomplete/improperly authorized payment requisitions will be returned without processing.

**NUMBER FINANCE 4.1**

Returned to departments for mailing. Please use that week.

APPLICANT COPY



**MILEAGE AND PARKING CLAIM FORM (WITHIN REGION)**

Program <i>EXEC</i>	Employee Name <i>Glenda Coleman-Miller</i>	Location <i>RAH</i>	Payroll #
------------------------	---	------------------------	-----------

NOTE: 1) It is the employee's responsibility to maintain adequate records to substantiate all mileage claims to Revenue Canada, Program Management, or Finance upon request. You must be able to provide documentation which shows the date, destination and km travelled on each of your trips. s.17(1), 17(4)(g)(i)

2) Driving to and from work is not considered business travel and must not be claimed.

Month <i>November</i>	Year <i>2005</i>
--------------------------	---------------------

Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	
1	9.5		9			17	16		25			
2			10	12		18			26			
3			11			19			27			
4			12			20			28			
5			13			21			29			
6			14			22			30	6	6 <sup>00</sup>	
7			15			23			31			
8			16	10	5 <sup>00</sup>	24						
										Total	53.5	11 <sup>00</sup>

Declaration: I hereby certify that the mileage and parking charges listed above were incurred on Capital-Health business and that the amount has not been previously claimed by me or on my behalf.

APPLICANT COPY

BELL TOWER FRENCH  
6274 0017707071 0001  
FRENCH

11-30-2003 WED #6

2 HOUR  
TOTAL 6.00  
CHARGE 6.00  
CHARGE 0.00

ITEM 1  
ID 6226 10:17PM

16-11-05

4 \*5.00

\*5.00 TL

\*10.00 NTD

\*5.00 MGR

8-08A

415-6520



**MILEAGE AND PARKING CLAIM FORM (WITHIN REGION)**

Program <i>EXEC</i>	Employee Name <i>Glenda Coleman-Miller</i>	Location <i>RATH</i>	Payroll #
------------------------	---	-------------------------	-----------

NOTE: 1) It is the employee's responsibility to maintain adequate records to substantiate all mileage claims to Revenue Canada, Program Management, or Finance upon request. You must be able to provide documentation which shows the date, destination and km travelled on each of your trips. s.17(1), 17(4)(g)(i)  
 2) Driving to and from work is not considered business travel and must not be claimed.

Month <i>December</i>	Year <i>2005</i>
--------------------------	---------------------

Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	Date	KM	Parking			
1			9			17			25					
2	<i>9</i>	<i>4.00</i>	10			18			26					
3			11			19			27					
4			12			20			28					
5			13	<i>16</i>		21			29					
6			14			22			30					
7			15			23			31					
8	<i>6</i>	<i>6.00</i>	16			24			<table border="1"> <tr> <td>Total</td> <td><i>15</i></td> <td><i>10.00</i></td> </tr> </table>			Total	<i>15</i>	<i>10.00</i>
Total	<i>15</i>	<i>10.00</i>												

Declaration: I hereby certify that the mileage and parking charges listed above were incurred on Capital Health business and that the amount has not been previously claimed by me or on my behalf.

Dec 8/05

BELL TOWER FINANCIAL  
6514 BELL TOWER BLVD  
PHOENIX

12-06-2005 THU #0

2 HOUR  
TOTAL 6.00  
CHARGE 7.00  
CHANGE 1.00

LAY FACE UP

SH DISPLAY FACE UP ON DASH

DISP  
CALLS/BOOKS COMMENTS?  
Call 700 420 1976  
DISP  
ON DASH

EXP 01:44pm  
DEC 02, 2005  
TICKET# 00011665 LOT# 00020256  
Lot # 00020256  
MATCH # 00011665  
EXP 01:44pm  
DEC 02 2005  
Lot # 00020256  
MATCH # 00011665

DISPLAY FACE UP ON DASH

s.17(1), 17(4)(e.1)





# APPLICANT COPY

Accounting Services  
10<sup>th</sup> Floor, North Tower CHC  
10030-107 St.  
Edmonton, Alberta T5J 3E4

## Payment Requisition

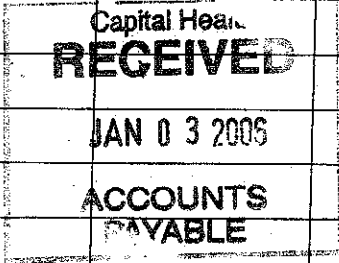
**I PAYEE INFORMATION** (Check one only)  Vendor  Patient  Employee (EE number )

Invoice Date **12-Dec-05** (DD-MMM-YY) Invoice Number s.17(1), 17(4)(g)(i)  
 Vendor Number (or S.I.N.) Payee Name **Glenda Coleman-Miller**  
 Address s.17(1), 17(4)(g)(i) City  
 Province/State Postal Code Country

### II PAYMENT DETAILS

Reason for payment **Expenses for Open House, December 2005** PO #  
 Is this a contract payment?  Yes (Attach copy of contract if not previously forwarded)  No  
 If this is a contract payment, what is the contract date? Number  
 Have goods / services been received?  Yes, When? **1-Dec-05**  No  
 Are original attachments to be mailed with cheque? (Note 2)  Yes  No

### III EXPENSE CODES (IN ORACLE FINANCIAL SYSTEM FORMAT) (Departments must provide Complete Coding)

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Expense Sub-Total	GST if applicable	Total Payment
201	0002	711110101001	69500007	\$169.11		\$169.11
						
<input checked="" type="checkbox"/> Canadian	<input type="checkbox"/> U.S.	<input type="checkbox"/> Other	<b>TOTAL</b>	<b>\$169.11</b>		<b>\$169.11</b>

### IV AUTHORIZATION

I confirm that the above items have not been previously paid and the expenses related only to Capital Health business.

Requisitioned by (Print name) **Aileen Savage** Phone # **735-5272**  
 (Signature) *Aileen Savage* Date **19-Dec-05**  
 Approved by (Print name) **Glenda Coleman-Miller** Phone # **735-5271**  
 (Signature) *Glenda Coleman-Miller* Date **20-Dec-05**  
 Approved by (Print name) **Joanna Pawlyshyn** Phone # **735-4101**  
 (Signature) *Joanna Pawlyshyn* Date **23 Dec 05**

**AUTHORIZATIONS SHOULD BE IN ACCORDANCE WITH SIGNING AUTHORITY POLICY NUMBER FINANCE 4.1**

- Notes:
- 1) All employee payments will be made electronically based on payroll banking information.
  - 2) All cheques and attachments will be mailed out by Accounting Services. Cheques will NOT be pulled and returned to departments for mailing.
  - 3) Fully completed payment requisitions received in Accounting Services by **MONDAY, 4:00 p.m.** will be processed that week.
  - 4) Incomplete/improperly authorized payment requisitions will be returned without processing

APPLICANT COPY

the real Canadian Liquorstore  
 Refunds within 14 days with receipt  
 Your Cashier is MIKE

\*\* Minimum age verified \*\*

2 @ 15.29 ea Mult 6 / 85.14 30.58 G  
 BER, MERLOT  
 2 @ 0.05 ea Unit Price  
 CAT 89 .05 DEP 0.10  
 2 @ 9.79 ea Mult 6 / 54.54  
 BANROCK CAB,  
 2 @ 0.05 ea Unit Price 19.58 G  
 CAT 89 .05 DEP 0.10  
 2 @ 10.19 ea Mult 6 / 56.34  
 HENKELL TRDC 20.38 G  
 2 @ 0.05 ea Unit Price  
 CAT 89 .05 DEP 0.10  
 1 @ 13.19 ea Mult 6 / 73.14  
 FAT B, SHIRA 13.19 G  
 CAT 89 .05 DEP 0.05  
 1 @ 7.89 ea Limit Price 2  
 1 @ 9.19 ea Over The Limit 8  
 BIN 65 CHARD 17.08 G  
 2 @ 0.05 ea Unit Price  
 CAT 89 .05 DEP 0.10  
 1 @ 10.19 ea Mult 6 / 56.94  
 WOOD, S, BLAN 10.19 G  
 CAT 89 .05 DEP 0.05  
 2 @ 9.29 ea Mult 6 / 51.54  
 NOTTAGE CHD, 18.58 G  
 2 @ 0.05 ea Unit Price  
 CAT 89 .05 DEP 0.10  
 2 @ 7.99 ea Unit Price  
 S.R, VIGNIER 15.98 G  
 2 @ 0.05 ea Unit Price  
 CAT 89 .05 DEP 0.10  
 1 @ 11.79 ea Mult 6 / 65.34  
 FETZER GRIGIO 11.79 G  
 CAT 89 .05 DEP 0.05

7.0% G.S.T. 891353898 11.01

Balance Due 169.11

Cash 180.00

Cash

Change Due 10.89

Total Tax Paid 11.01




# APPLICANT COPY

Accounting Services  
10<sup>th</sup> Floor, North Tower CHC  
10030-107 St.  
Edmonton, Alberta T5J 3E4

## Payment Requisition

<b>I PAYEE INFORMATION</b> (Check one only)		<input type="checkbox"/> Vendor	<input type="checkbox"/> Patient	<input checked="" type="checkbox"/> Employee (EE number )		
Invoice Date <b>14-Feb-06</b> (DD-MMM-YY)	Invoice Number s.17(1), 17(4)(g)(i)					
Vendor Number (or S.I.N.)	Payee Name <b>Glenda Coleman-Miller</b>					
Address	s.17(1), 17(4)(g)(i)		City			
Province/State	Postal Code	Country				
<b>II PAYMENT DETAILS</b>						
Reason for payment <b>Re-imburement of CCHSE Power Breakfast Expense</b>			PO #			
Is this a contract payment? <input type="checkbox"/> Yes (Attach copy of contract if not previously forwarded) <input type="checkbox"/> No						
If this is a contract payment, what is the contract date?			Number			
Have goods / services been received? <input checked="" type="checkbox"/> Yes, When? <b>16-Jan-06</b> <input type="checkbox"/> No						
Are original attachments to be mailed with cheque? (Note 2) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
<b>III EXPENSE CODES (IN ORACLE FINANCIAL SYSTEM FORMAT)</b> (Departments must provide Complete Coding)						
Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Expense Sub-Total	GST if applicable	Total Payment
201	0002	71110101001	61030000	\$20.00		\$20.00
<div style="border: 2px solid black; padding: 5px; width: fit-content; margin: auto;"> <p>Capital Health <b>RECEIVED</b> FEB 22 2006 ACCOUNTS PAYABLE</p> </div>						
<input checked="" type="checkbox"/> Canadian <input type="checkbox"/> U.S. <input type="checkbox"/> Other			<b>TOTAL</b>	<b>\$20.00</b>		<b>\$20.00</b>
<b>IV AUTHORIZATION</b>						
I confirm that the above items have not been previously paid and the expenses related only to Capital Health business.						
Requisitioned by (Print name) <b>Aileen Savage</b>				Phone # <b>735-5272</b>		
(Signature) <i>Aileen Savage</i>				Date <b>14-Feb-06</b>		
Approved by (Print name) <b>Glenda Coleman-Miller</b>				Phone # <b>735-5271</b>		
(Signature) <i>Glenda Coleman-Miller</i>				Date <b>15-FEB-06</b>		
Approved by (Print name) <b>Joanna Pawlyshyn</b>				Phone # <b>735-4101</b>		
(Signature) <i>Joanna Pawlyshyn</i>				Date <b>17 Feb 06</b>		
<b>AUTHORIZATIONS SHOULD BE IN ACCORDANCE WITH SIGNING AUTHORITY POLICY NUMBER FINANCE 4.1</b>						
Notes:						
1) All employee payments will be made electronically based on payroll banking information.						
2) All cheques and attachments will be mailed out by Accounting Services. Cheques will NOT be pulled and returned to departments for mailing.						
3) Fully completed payment requisitions received in Accounting Services by <b>MONDAY, 4:00 p.m.</b> will be processed that week.						
4) <b>Incomplete/improperly authorized payment requisitions will be returned without processing</b>						

# APPLICANT COPY

 Canadian College of Health Service Executives Collège canadien des directeurs de services de santé		<b>RECEIPT</b>  <b>Northern Alberta Chapter Power Breakfast Program</b>				
<b>Date:</b>		January 16, 2006				
<b>Received From:</b>		Glenda Coleman-Miller			Member <input checked="" type="checkbox"/> Non Member <input type="checkbox"/> Student <input type="checkbox"/>	
Session 1	Session 2	Session 3	Session 4	Session 5	Session 6	Session 7
			X			
<b>Total: \$ ---\$20.00---</b> <b>PAID CASH</b>				Individual Sessions: M=\$20 NM=\$30 Students: M=\$10 NM=\$15 All 6 Sessions: M=\$96 NM=\$154		



# APPLICANT COPY

Accounting Services  
10<sup>th</sup> Floor, North Tower CHC  
10030-107 St.  
Edmonton, Alberta T5J 3E4

## Payment Requisition

<b>I PAYEE INFORMATION</b> (Check one only)		<input type="checkbox"/> Vendor	<input type="checkbox"/> Patient	<input checked="" type="checkbox"/> Employee (EE number)		
Invoice Date <b>17-Mar-06</b> (DD-MMM-YY)	Invoice Number s.17(1), 17(4)(g)(i)					
Vendor Number (or S.I.N.)	Payee Name <b>Glenda Coleman-Miller</b>					
Address	s.17(1), 17(4)(g)(i)		City			
Province/State	Postal Cod	Country				
<b>II PAYMENT DETAILS</b>						
Reason for payment <b>Re-imbursment for CARNA Conference Registration</b>			PO #			
Is this a contract payment?			<input type="checkbox"/> Yes (Attach copy of contract if not previously forwarded)	<input checked="" type="checkbox"/> No		
If this is a contract payment, what is the contract date?			Number			
Have goods / services been received?			<input type="checkbox"/> Yes, When?	<input checked="" type="checkbox"/> No		
Are original attachments to be mailed with cheque? (Note 2)			<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No		
<b>III EXPENSE CODES (IN ORACLE FINANCIAL SYSTEM FORMAT)</b> (Departments must provide Complete Coding)						
Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Expense Sub-Total	GST if applicable	Total Payment
201	0002	71110101001	61030000	\$240.75		\$240.75
				<div style="border: 1px solid black; padding: 5px; text-align: center;">           Capital Health  <b>RECEIVED</b>            MAR 23 2006            ACCOUNTS            PAYABLE         </div>		
<input checked="" type="checkbox"/> Canadian	<input type="checkbox"/> U.S.	<input type="checkbox"/> Other	<b>TOTAL</b>	<b>\$240.75</b>		<b>\$240.75</b>
<b>IV AUTHORIZATION</b>						
I confirm that the above items have not been previously paid and the expenses related only to Capital Health business.						
Requisitioned by (Print name) <b>Aileen Savage</b>				Phone # <b>735-5272</b>		
(Signature) <i>Aileen Savage</i>				Date <b>17-Mar-06</b>		
Approved by (Print name) <b>Glenda Coleman-Miller</b>				Phone # <b>735-5271</b>		
(Signature) <i>Glenda Coleman-Miller</i>				Date <b>17-Mar-06</b>		
Approved by (Print name) <b>Joanna Pawlyshyn</b>				Phone # <b>735-4101</b>		
(Signature) <i>Joanna Pawlyshyn</i>				Date <b>22 Mar 06</b>		
<b>AUTHORIZATIONS SHOULD BE IN ACCORDANCE WITH SIGNING AUTHORITY POLICY NUMBER FINANCE 4.1</b>						
Notes:						
1) All employee payments will be made electronically based on payroll banking information.						
2) All cheques and attachments will be mailed out by Accounting Services. Cheques will NOT be pulled and returned to departments for mailing.						
3) Fully completed payment requisitions received in Accounting Services by MONDAY, 4:00 p.m. will be processed that week.						
4) Incomplete/improperly authorized payment requisitions will be returned without processing						



RN Pride and Professionalism  
 Annual Conference & General Meeting  
 April 20-22, 2006  
 The Westin Hotel  
 Edmonton  
 Alberta

contact information

Name: Glenda Coleman-1  
 Address: Rm 1108, ATC ROYAL  
 City/Town: Edmonton Province: \_\_\_\_\_  
 Phone - Hm: ( ) \_\_\_\_\_ Phone - \_\_\_\_\_  
 Fax: 780 735-5273 E-mail: \_\_\_\_\_  
 CARNA Reg. #: \_\_\_\_\_ s.17(1), 17(4)(g)(i)  
 Please specify any special needs (i.e.: diet, accessibility) that \_\_\_\_\_

CHANDRA HOSPITAL  
 Postal Code: T5H 3V9  
735-5271  
nan@cha.ab.ca

Institution: \_\_\_\_\_  
 To bring to the attention of CARNA or the hotel.

registration – deadline for all registrations is April 15, 2006

- Earlybird Full Conference Registration – On or before April 15, 2006  
 (Includes all conference sessions, lunches and one Gala Awards Dinner)
- Regular Full Conference Registration – After March 15, 2006  
 (Includes all conference sessions, lunches and one Gala Awards Dinner)
- Student Registration  
 (Includes all conference sessions on both days, lunch and one Gala Awards Dinner)
- I would like to sponsor a student to attend the conference  
 (Includes all conference sessions on both days, lunch and one Gala Awards Dinner)
- I will attend the CARNA Annual General Meeting (Noon – 2 p.m., Includes lunch)

April 20	\$225 + 15.75 GST	\$240.75
	Gala Awards Dinner)	
	\$275 + 19.25 GST	\$294.25
	Gala Awards Dinner)	
	\$75 + 5.25 GST	\$80.25
	(NOT include ticket to the Gala Awards Dinner)	
	\$75 + 5.25 GST	\$80.25
	(NOT include ticket to the Gala Awards Dinner)	
April 20		No charge

I require extra ticket(s):

- Individual CARNA Awards Gala ticket(s) on April 20  
 this is a fragrance free conference  
 Tickets/confirmation of registration will not be made without payment.  
 Requests for refunds will not be considered unless received prior to April 1, 2006

+ 4.25 GST= \$65.00 x \_\_\_\_\_ (of tickets) \_\_\_\_\_  
 Total \_\_\_\_\_

payment (CARNA GST # R106692643)

- My cheque for \$ 240.75 and made payable to \_\_\_\_\_
- My cheque for \$ 240.75 will follow by mail.
- Please charge \$ \_\_\_\_\_ to my  VISA  MasterCard  American Express  
 Card #: \_\_\_\_\_

Registration is tax deductible.  
 Received prior to April 1, 2006

Name of card holder: \_\_\_\_\_

Expiry Date(mmm/yy): \_\_\_\_\_  
 Name of card holder: \_\_\_\_\_

please complete this order form and return to  
 2006 CARNA Conference  
 Box 31051, Namao Centre, Edmonton, AB T5Z 3P3  
 Fax:(780) 401-3085

Accommodation: Rooms are available at a special rate of \$129 /double occupancy. To guarantee this rate, book your room before April 20, 2006, by calling the Westin Hotel at 780.426.3636 or 1-800-441-1111. Please indicate you are attending the College and Association of Registered Nurses of Alberta Conference.

Inquiries: Phone:(780) 401-3085 mail: events@TL2.ca

You can also register on-line via secure server at: [www.nurses.ab.ca](http://www.nurses.ab.ca)

APPLICANT COPY

CI ENDA D COLEMAN-MILLER

s.17(1), 17(4)(g)

**VIP**

DATE 16 03 2006

792

PAY TO THE ORDER OF

CARNA

\$ 240.75

Two hundred forty

75

100 DOLLARS

Security features included. Details on back.



ROYAL BANK OF CANADA  
TERWILLEGAR HEIGHTS BRANCH  
14711 40TH AVENUE, UNIT A 121  
EDMONTON, AB T6R 1N1

MEMO

re. registration for Coleman-Miller  
Annual Conference

s.17(1), 17(4)(e.1)



APPLICANT COPY

Registered: 06 Mar 07

Travel & Employee Expense Claim Form

(In Canadian Dollars) §.17(1), 17(4)(g)(i)

Name: Glenda Coleman-Miller	Employee Number:	Union Name:
Position: Senior Operating Officer	Department: RAH Exec	
Business Phone: 735-5271	Period From: to	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0002	71110101001	61030000			\$300.00	<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
Total						\$300.00	<input type="checkbox"/>

Capital Health  
**RECEIVED**  
MAR 19 2007  
ACCOUNTS  
PAYABLE

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: *Glenda Coleman-Miller* Date: March 15, 2007

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: Joanna Pawlyshyn (Print name)	Title: V.P. & C.O.O.	Phone # 735-4101
(Signature)		Date
Approved By:	Title:	Phone #
(Signature)		Date

NOTE:

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
- GST amounts included in the expense claims will be calculated by Accounts Payable.
- Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
- For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
- For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
- See page 2 of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP



**EXPENSES ONLY**

<b>Recommended Coding</b>							
<ul style="list-style-type: none"> <li>• Local Travel – Staff - 62410000</li> <li>• Staff Local Travel – Taxi – 62410001</li> <li>• Staff Travel – UNA – 62410002</li> <li>• Staff Provincial Travel – 62412000 (all expenses)</li> <li>• Staff Out of Province Travel – 62414000 (all expenses)</li> </ul>				<ul style="list-style-type: none"> <li>• Catering – 69600000</li> <li>• Meals - 62410000</li> <li>• Mileage – 62410000</li> <li>• Course Registration &amp; Materials – 61030000</li> </ul>			
Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
March 2/07	Registration for Healthy Mothers & Healthy Babies Conference in Calgary - May 2007			\$300.00			
<b>Total km</b>							
<b>Rate as outlined in Section 2 – Travel below @</b>							
<b>Totals</b>				\$300.00			

**EXPENSE LIMITS**

1. **Meal Allowances**  
 When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:
  - Breakfast    \$8.50 (if the departure time is earlier or the return time is later than 7:30 a.m.)
  - Lunch            \$10.75 (if the departure time is earlier or the return time is later than 1:00 p.m.)
  - Dinner           \$19.20 (if the departure time is earlier or the return time is later than 6:30 p.m.)
 For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.  
 Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.
2. **Travel**
  - Use of personal automobile – From March 1, 2006, reimbursement at the general rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
  - Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
  - Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
    1. Monthly travel in excess of 340 kilometers; or
    2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
    3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
  - If union contract rate differs from \$0.43 then contract rate must be used.
  - Includes all forms of transportation costs, including taxis and buses for local travel.
  - Driving to and from work is not considered business travel and cannot be claimed.

APPLICANT COPY



Healthy Mothers, Healthy Babies:  
 How to Prevent Low Birth Weight  
 May 23 to 25, 2007  
 The Sheraton Suites Calgary Eau Claire

**RECEIPT**  
 GST # R124072513

Date	Receipt No.
03/06/2007	A000058

**Payer:**

Glenda Coleman-Miller  
 Royal Alexandra Hospital, 10240 Kingsway Avenue  
 Edmonton, AB T5H 3V9

Inv No.	Description	Total Fees	Tax	Applied Amount				
A0000062	Registration for Glenda Coleman-Miller for the event: <i>Healthy Mothers, Healthy Babies</i>	\$300.00		\$300.00				
		<b>GST =</b>	\$0.00					
		<b>Total Fees w/Tax</b>		\$300.00				
<table border="1"> <tr> <td>Visa:</td> <td></td> </tr> <tr> <td>s.17(1), 17(4)(e.1)</td> <td></td> </tr> </table>		Visa:		s.17(1), 17(4)(e.1)		<b>Total Paid</b>		\$300.00
Visa:								
s.17(1), 17(4)(e.1)								
		<b>Total Applied</b>		\$300.00				
		<b>Unapplied Balance</b>		0.00				

Thank you for your payment received on 03/06/2007.

Note: If you paid by credit card, your statement will read **BUKSA Assoc. (780) 436-0983 Edm.**

---

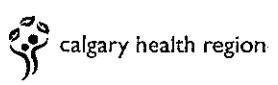
**Healthy Mothers, Healthy Babies: How to Prevent Low Birth Weight**  
 c/o BUKSA Conference Management and Program Development  
 Suite 307, 10328 - 81 Avenue NW Edmonton AB T6E 1X2  
 Phone: (780) 436-0983 ext. 229 Fax: (780) 437-5984 E-mail: lowbirthweight@BUKSA.com

**Advance  
Program  
and  
Registration**

**A Consensus Development Conference on**  
**Healthy Mothers –**  
**Healthy Babies**  
**How to Prevent Low Birth Weight**

May 23 to 25, 2007  
Sheraton Suites Calgary Eau Claire  
Calgary / Alberta / Canada

Hosted By:





**APPLICANT COPY**  
**Travel & Employee Expense Claim Form**

*Reimburse - 18 Dec*

*(In Canadian Dollars)* s.17(1), 17(4)(g)(i)

<b>Name:</b> Glenda Coleman-Miller	<b>Employee Number:</b>	<b>Union Name:</b>
<b>Position:</b> Senior Operating Officer		<b>Department:</b> RAH - Exec
<b>Business Phone:</b> 735-5271	<b>Period From:</b> Oct to December 2006	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0002	71110101001	62410000			\$95.00	<input checked="" type="checkbox"/>
201	0002	71110101001	62410000			137.17	<input checked="" type="checkbox"/>
						96.32	<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
<b>Less Cash Advance</b>							<input type="checkbox"/>
<b>Total</b>						\$232.17	<input type="checkbox"/>

Capital Health  
**RECEIVED**  
JAN 08 2007  
ACCOUNTS  
PAYABLE

191.32

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: *Glenda Coleman-Miller* Date: December 19, 2006

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

<b>Approved By:</b> Joanna Pawlyshyn <i>(Print name)</i>	<b>Title:</b> V.P. & C.O.O.	<b>Phone #</b> 735-4101
<i>(Signature)</i>	02 JAN 07	<b>Date</b>
<b>Approved By:</b>	<b>Title:</b>	<b>Phone #</b>
<i>(Signature)</i>		<b>Date</b>

**NOTE:**

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
- GST amounts included in the expense claims will be calculated by Accounts Payable.
- Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
- For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
- For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
- See page 2 of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

**EXPENSE CLAIM DETAILS**  
**APPLICANT COPY**

**Recommended Coding**

- Local Travel – Staff - 62410000
  - Staff Local Travel – Taxi – 62410001
  - Staff Travel – UNA – 62410002
  - Staff Provincial Travel – 62412000 (all expenses)
  - Staff Out of Province Travel – 62414000 (all expenses)
- Catering – 69600000
  - Meals – 62410000
  - Mileage – 62410000
  - Course Registration & Materials – 61030000

Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
Sept. 06	Parking - not previously reported				\$12.00	✓	
October 2006	Mileage and Parking				15.00	✓	40
November 2006	Mileage and Parking				37.00	✓	72
December 2006	Mileage and parking				31.00	✓	112
<b>Total km</b>							224
<b>Rate as outlined in Section 2 – Travel below @</b>							0.43
<b>Totals</b>					\$95.00		\$137.17

*96.32*  
*adding error*

**EXPENSE LIMITS**

1. **Meal Allowances**  
When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:
  - Breakfast \$8.50 (if the departure time is earlier or the return time is later than 7:30 a.m.)
  - Lunch \$10.75 (if the departure time is earlier or the return time is later than 1:00 p.m.)
  - Dinner \$19.20 (if the departure time is earlier or the return time is later than 6:30 p.m.)
 For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.  
Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.
  
2. **Travel**
  - Use of personal automobile – From March 1, 2006, reimbursement at the general rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
  - Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
  - Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
    1. Monthly travel in excess of 340 kilometers; or
    2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
    3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
  - If union contract rate differs from \$0.43 then contract rate must be used.
  - Includes all forms of transportation costs, including taxis and buses for local travel.
  - Driving to and from work is not considered business travel and cannot be claimed.

APPLICANT COPY



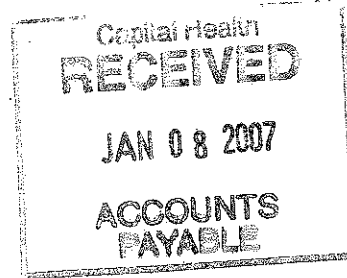
MILEAGE AND PARKING CLAIM FORM (WITHIN REGION)

Program <i>EXEC</i>	Employee Name <i>Glonda Coleman-Muller</i>	Location <i>RAT</i>	Payroll #
------------------------	---	------------------------	-----------

s.17(1), 17(4)(g)(i)

NOTE: 1) It is the employee's responsibility to maintain adequate records to substantiate all mileage claims to Revenue Canada, Program Management, or Finance upon request. You must be able to provide documentation which shows the date, destination and km travelled on each of your trips.  
2) Driving to and from work is not considered business travel and must not be claimed.

Month <i>SEPT/OCT</i>	Year <i>2006</i>
--------------------------	---------------------



Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	Date	KM	Parking
1			9			17			25		
2			10			18	<i>8</i>	<i>6.00</i>	26		
3			11	<i>16</i>	<i>4.50</i>	19			27		
4			12	<i>16</i>	<i>4.50</i>	20			28		
5			13			21			29		
6			14			22			30		
7			15			23			31		
8	<i>(Sept)</i>	<i>12.00</i>	16			24					

Total	<i>40</i>	<i>27.00</i>
-------	-----------	--------------

Declaration: I hereby certify that the mileage and parking charges listed above were incurred on Capital Health business and that the amount has not been previously claimed by me or on my behalf.

UNIVERSITY OF ALBERTA  
HOSPITAL 114 ST.  
THANK YOU FOR PARKING

*SAP*

UNIVERSITY OF ALBERTA  
HOSPITAL 114 ST.  
THANK YOU FOR PARKING

*02*

UNIVERSITY OF ALBERTA  
HOSPITAL 114 ST.  
THANK YOU FOR PARKING

*02*

*02*

Rate# 52309  
09/29/06 11:29 LN 1 AM 2 TANK49235  
09/29/06 07:27 In 09/29/06 11:28 Out  
TICK 52304  
DAILY RATE \$ 12.00  
TOTAL FEE \$ 12.00  
CASH PAID \$ 12.00  
CASH TENDER \$ 0.00  
Change Due

Rate# 48592  
10/11/06 10:24 LN 1 AM 3 TANK47896  
10/11/06 14:58 In 10/11/06 18:21 Out  
TICK 58397  
DAILY RATE \$ 4.50  
TOTAL FEE \$ 4.50  
CASH PAID \$ 4.50  
CASH TENDER \$ 0.00  
Change Due \$ 0.00

Rate# 48924  
10/12/06 13:07 LN 1 AM 3 TANK47896  
10/12/06 11:47 In 10/12/06 13:07 Out  
TICK 52443  
DAILY RATE \$ 4.50  
TOTAL FEE \$ 4.50  
CASH PAID \$ 4.50  
CASH TENDER \$ 0.00  
Change Due

TELLUS PARKADE  
651 INC. RM122388333  
06DETT18 16:21 001 002  
06DETT18 14:47  
/ 1:34 #151611  
RATE 1 \$6.00  
TOTAL \$6.00  
CASH \$6.00

MANAGED BY  
IMPERIAL PARKING

APPLICANT COPY

APPLICANT COPY



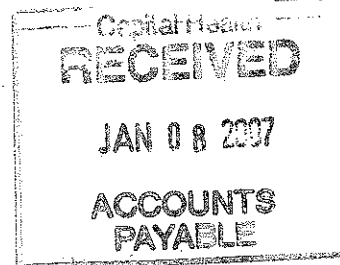
**MILEAGE AND PARKING CLAIM FORM (WITHIN REGION)**

Program <i>EXEC</i>	Employee Name <i>Glenda Coleman-Miller</i>	Location <i>RPH</i>	Payroll #
------------------------	---	------------------------	-----------

s.17(1), 17(4)(g)(i)

NOTE: 1) It is the employee's responsibility to maintain adequate records to substantiate all mileage claims to Revenue Canada, Program Management, or Finance upon request. You must be able to provide documentation which shows the date, destination and km travelled on each of your trips.  
2) Driving to and from work is not considered business travel and must not be claimed.

Month <i>November</i>	Year <i>2006</i>
--------------------------	---------------------



Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	Date	KM	Parking
1			9			17			25		
2			10	<i>16</i>	<i>5.40</i>	18			26		
3			11			19			27		
4			12			20			28	<i>16</i>	<i>10.50</i>
5			13			21	<i>8</i>	<i>7.00</i>	29		
6	<i>16</i>	<i>6.00</i>	14			22			30		
7			15			23			31		
8	<i>16</i>	<i>8.10</i>	16			24					
									Total	<i>72</i>	<i>37.00</i>

Declaration: I hereby certify that the mileage and parking charges listed above were incurred on Capital Health business and that the amount has not been previously claimed by me or on my behalf.



APPLICANT COPY

CAPITAL HEALTH  
UNIVERSITY HOSPITAL PUBLIC PARKING

Receipt# 23192  
11/10/06 12:47 LH 1 AM 2 TKN# 52665  
11/10/06 10:52 In 11/10/06 12:47 Out  
TKN# 937411  
Daily Rate \$ 5.40  
Total Fee \$ 5.40  
CASH PAID \$ 5.40-  
Cash Tender \$ 5.40  
Change Due \$ 0.00

CAPITAL HEALTH  
UNIVERSITY HOSPITAL PUBLIC PARKING

Receipt# 22639  
11/09/06 11:40 LH 1 AM 2 TKN# 52099  
11/09/06 09:00 In 11/09/06 11:40 Out  
TKN# 934984  
Daily Rate \$ 8.10  
Total Fee \$ 8.10  
CASH PAID \$ 8.10-  
Cash Tender \$ 8.10  
Change Due \$ 0.00

UNIVERSITY OF ALABAMA  
HOSPITAL 114 St.  
THANK YOU FOR PARKING

Receipt# 60691  
11/06/06 09:39 LH 1 AM 2 TKN# 93379  
11/06/06 09:01 In 11/06/06 09:39 Out  
TKN# 606606  
Daily Rate \$ 6.00  
Total Fee \$ 6.00  
TKN# PAID \$ 6.00-  
Cash Tender \$ 20.00  
Change Due \$ 14.00

Imperial Parking  
Lot 0002-161  
G.S.T. #88731 5638 RT0001  
Machine Serial #887315001

EXPIRY DATE AND TIME : AP 06:00pm  
OV 21,2006

**EXP 06:00pm**  
**NOV 21,2006**

TICKET# 00009125 LOT# 00020161

OT# 00020161  
ALH# 001  
IC# 00002746  
IC \$0007.00  
000212006  
127am  
Purchase Time

s.17(1), 17(4)(e.1)

*Man*

Early Bird \$7.00

Questions/Comments  
Call 780-420-1976



DATE 28/11/06  
LOT 96  
TICKET No. 613648  
AMOUNT 10.50  
SIGNATURE [Signature]  
G.S.T. #88731 5638 RT0001 IM - 003

APPLICANT COPY



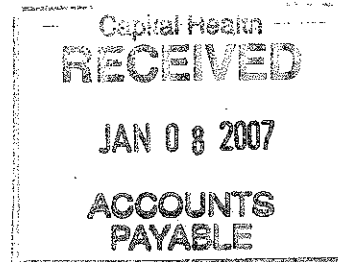
**MILEAGE AND PARKING CLAIM FORM (WITHIN REGION)**

Program <i>EXEC</i>	Employee Name <i>Glenda Coleman Miller</i>	Location <i>RAH</i>	Payroll #
------------------------	---	------------------------	-----------

s.17(1), 17(4)(g)(i)

NOTE: 1) It is the employee's responsibility to maintain adequate records to substantiate all mileage claims to Revenue Canada, Program Management, or Finance upon request. You must be able to provide documentation which shows the date, destination and km travelled on each of your trips.  
2) Driving to and from work is not considered business travel and must not be claimed.

Month <i>December</i>	Year <i>2006</i>
--------------------------	---------------------



Date	KM	Parking	Date	KM	Parking	Date	KM	Parking	Date	KM	Parking
1			9			17			25		
2			10			18	<i>16</i>	<i>10.50</i>	26		
3			11	<i>16</i>		19			27		
4	<i>16</i>		12			20			28		
5	<i>16</i>		13	<i>16</i>		21			29		
6			14			22			30		
7	<i>16</i>	<i>6.75</i>	15			23			31		
8	<i>16</i>	<i>13.75</i>	16			24					

Total	<i>112</i>	<i>31.00</i>
-------	------------	--------------

Declaration: I hereby certify that the mileage and parking charges listed above were incurred on Capital Health business and that the amount has not been previously claimed by me or on my behalf.

APPLICANT COPY

UNIVERSITY OF ALBERTA  
HOSPITAL 93 AVE  
THANK YOU FOR PARKING

Receipt 9174  
12/07/06 10:16 LH 1 AM 2 TKN 24543  
12/07/06 08:01 In 12/07/06 10:16 Out  
TKN 953862  
Daily Rate \$ 6.75  
Total Fee \$ 6.75  
CASH PAID \$ 6.75-  
Cash Tender \$ 6.75  
Change Due \$ 0.00

UNIVERSITY OF ALBERTA  
HOSPITAL 117 ST  
THANK YOU FOR PARKING

Receipt 7417  
12/12/06 09:00 LH 1 AM 4 TKN 07099  
12/12/06 14:50 In 12/12/06 26:00 Out  
TKN 097492  
Daily Rate \$ 10.50  
Total Fee \$ 10.50  
CASH PAID \$ 10.50-  
Cash Tender \$ 10.50  
Change Due \$ 0.00

DISPLAY THIS SIDE UP ON DASHBOARD

EXPIRATION DATE      EXPIRATION TIME  
09/12 06:45 AM

AMOUNT PAID  
\$ 13.75 1521000007:43 AM



UNIVERSITY OF ALBERTA

NON TRANSFERABLE

DETACH RECEIPT FROM TICKET

DATE ISSUED      TIME ISSUED      AMOUNT PAID  
09/12/06 07:43 AM \$ 13.75

CREDIT CARD NUMBER

s.17(1), 17(4)(e.1)



UNIVERSITY OF ALBERTA

RECEIPT

GST # R108102831



**APPLICANT COPY**  
**Travel & Employee Expense Claim Form**  
*(In Canadian Dollars)*

OTTAWA, ON

s.17(1), 17(4)(g)(i)

<b>Name:</b> Glenda Coleman-Miller	<b>Employee Number:</b>	<b>Union Name:</b>
<b>Position:</b> Senior Operating officer		<b>Department:</b> Patient Care Administration
<b>Business Phone:</b> 735-5271	<b>Period From:</b> February 4 to February 7, 2007	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0002	71110101001	62414000			\$901.42	<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
<b>Less Cash Advance</b>							<input type="checkbox"/>
<b>Total</b>						\$901.42	<input type="checkbox"/>

Capital Health  
**RECEIVED**  
 FEB 26 2007  
 ACCOUNTS  
 PAYABLE

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

(7) 863.57

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

**Employee Signature:** *Glenda Coleman-Miller* **Date:** February 22, 2007

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed. (N) 37.86

<b>Approved By:</b> Joanna Pawlyshyn <i>(Print name)</i>	<b>Title:</b> V.P. & C.O.O.	<b>Phone #</b> 735-4101
<i>(Signature)</i>	23 Feb 07	<b>Date</b>
<b>Approved By:</b>	<b>Title:</b>	<b>Phone #</b>
<i>(Signature)</i>		<b>Date</b>

- NOTE:**
- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
  - GST amounts included in the expense claims will be calculated by Accounts Payable.
  - Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
  - For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
  - For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
  - See page 2 of this form for expense claim limits.
  - Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
  - Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP



# APPLICANT COPY

the westin ottawa  
 11 colonel by drive ottawa, ontario k1n 9h4 canada  
 phone 613.560.7000 fax 613.560.7359  
 westin.com/ottawa

guest

Mrs Glenda Coleman-miller

travel agent/charge to

Royal Alexander Hospital  
 10240 Kingsway  
 Edmonton, AB T5H 3B9  
 Canada  
 GNUR07

room 1729  
 rate 259.00  
 no. pers. 1  
 folio 167697 EX-A  
 page 1  
 arrive 04-FEB-07  
 depart 07-FEB-07  
 payment VI

DATE	FOLIO	DESCRIPTION	AMOUNT
04-FEB-07	RT1729	Room	169.00
04-FEB-07	RT1729	G.S.T. Room 6%	10.14
04-FEB-07	RT1729	P.S.T. Room 5% ✓	8.45 ✓
04-FEB-07	RT1729	DMF Fee 2.83%	4.78
04-FEB-07	RT1729	GST On DMF 6%	0.29
04-FEB-07	1522	Casual Restaurant	53.00
05-FEB-07	RT1729	Room	169.00
05-FEB-07	RT1729	G.S.T. Room 6%	10.14
05-FEB-07	RT1729	P.S.T. Room 5% ✓	8.45 ✓
05-FEB-07	RT1729	DMF Fee 2.83%	4.78
05-FEB-07	RT1729	GST On DMF 6% Non-Responsive	0.29
<del>05-FEB-07</del>			<del>20.16</del>
05-FEB-07	2435	HighSpeedInternet	12.95
05-FEB-07	2435	6% GST Internet Tax	0.78
05-FEB-07	761A	0006 22:36 s.17(1), 17(4)(g)(i)	1.50
05-FEB-07	761A	Telephone Tax GST 6%	0.09
06-FEB-07	RT1729	Room	259.00
06-FEB-07	RT1729	G.S.T. Room 6%	15.54
06-FEB-07	RT1729	P.S.T. Room 5% ✓	12.95 ✓
06-FEB-07	RT1729	DMF Fee 2.83%	7.33
06-FEB-07	RT1729	GST On DMF 6%	0.44
06-FEB-07	939A	0002 17:22	1.50
06-FEB-07	966A	0005 17:28 s.17(1), 17(4)(g)(i)	1.50
<del>06-FEB-07</del>			<del>30.70</del>
07-FEB-07	VI	Visa Non-Responsive	830.75-
		Total Charges	830.75
		Total Credits	830.75-
		Balance Due	0.00

751.90

\*\* continued on the next page \*\*

I agree to remain personally liable for the payment of this account if the corporation or other third party billed fails to pay part or all of these charges.

signature \_\_\_\_\_

Mrs Glenda Coleman-miller  
 FOLIO 167697 04-FEB-07

# APPLICANT COPY

the westin ottawa  
 11 colonel by drive ottawa, ontario k1n 9h4 canada  
 phone 613.560.7000 fax 613.560.7359  
 westin.com/ottawa

guest

travel agent/charge to

Mrs Glenda Coleman-miller	room	1729	
	rate	259.00	
Royal Alexander Hospital	no. pers.	1	
10240 Kingsway	folio	167697	EX-A
Edmonton, AB T5H 3B9	page	2	
Canada	arrive	04-FEB-07	
GNUR07	depart	07-FEB-07	
	payment	VI	

For your convenience, we have prepared this zero-balance folio indicating a \$0 balance on your account. Please be advised that any charges not reflected on this folio will be charged to the credit card on file with the hotel. While this folio reflects a \$0 balance, your credit card may not be charged until after your departure. You are ultimately responsible for paying all of your folio charges in full.

**EXPENSE REPORT SUMMARY**

Date	Other	Total	Payment
04-FEB-07	245.66	245.66	0.00
05-FEB-07	228.14	228.14	0.00
06-FEB-07	356.95	356.95	0.00
Total	830.75	830.75	0.00

Thank you for choosing Starwood Hotels. We look forward to welcoming you back soon!

**GST Summary for your stay:**

Room Revenue GST:	36.84
Food & Beverage GST:	2.46
Phone/Fax/Copy Services GST:	0.09
Other Revenue GST:	0.00
<b>Total GST for your stay:</b>	<b>39.39</b>

The Westin Ottawa GST vendor # 861336493RT002

I agree to remain personally liable for the payment of this account if the corporation or other third party billed fails to pay part or all of these charges.

signature \_\_\_\_\_

As a Starwood Preferred Guest you have earned at least 1233 Starpoints for this visit

Mrs Glenda Coleman-miller s.17(1), 17(4)(g)(i)  
 FOLIO 167697 04-FEB-07

Thank You for calling Capital Taxi.ca

Date: Feb 4/07 Amount: 48.00  
From:

To: Airport  
Unit: 107 Driver: VJG est: s.17(1), 17(4)(g)(i)

24 Hour Service  
423-2425  
VISA  
MasterCard



RECEIPT FOR CAB FARE

Job #

Amount: 32.00 Date: Feb 7-07

From

To

Cab No.

G.S.T. included in meter fare

Driver: A. Thelma



# APPLICANT COPY

Cora's  
179 Rideau Street  
(613) 241-7842

Cash# 1  
Serv: Amy  
Table: 21B Bill# 93  
#Clients: 1  
2007/02/07 10:35

1 CORA'S SPECIAL  
1 REGULAR COFFEE

8.35  
1.75

Sub Total: 10.10  
GST %6.00 0.61  
PST %8.00 0.81  
Total: 11.52

CASH 20.00

Charge: 8.48

TAX 87474001

Thank You  
Have a great day!

CHARGE TO: ACCOUNT NO. s.17(1), 17(4)(e.1)

04/04 V

G. COLEMAN MILLER

YELLOW CAB (780) 462-3456  
PRESTIGE (780) 462-4444  
ADMINISTRATION (780) 465-8500

AUTH. NO.	DRIVER	UNIT NO.
	A109397	
TIME	DAY	MO. YR.
	07	02 07

2459328

FARE	52-
INTL	
GRATUITY	3.00
TOTAL	60.00

G.S.T.# R133361782

FROM: IAP

TC

PRINT NAME: s.17(1), 17(4)(g)(i)

CUSTOMER'S SIGNATURE: G. Coleman Miller

Diners Club International  
 MasterCard  
 VISA  
 AMERICAN EXPRESS

THE ISSUER OF THE CARD IDENTIFIED ON THIS ITEM IS AUTHORIZED TO PAY THE AMOUNT SHOWN AS TOTAL UPON PROPER PRESENTATION. I PROMISE TO PAY SUCH TOTAL TOGETHER WITH ANY OTHER CHARGES DUE THEREON SUBJECT TO AND IN ACCORDANCE WITH THE AGREEMENT COVERING THE USE OF SUCH CARD.





# APPLICANT COPY

## Travel & Employee Expense Claim Form

(In Canadian Dollars)

s.17(1), 17(4)(g)(i)

Name: Glenda Coleman-Miller	Employee Number:	Union Name:
Position: Senior Operating Officer	Department: Executive	
Business Phone: 735-5271	Period From: Feb. 27 to February 27, 2007	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0002	711101001	<del>02410000</del>	69600000		\$2,087.86	<input checked="" type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
<b>Total</b>						\$2,087.86	<input checked="" type="checkbox"/>

Capital Health  
**RECEIVED**  
MAR 08 2007  
ACCOUNTS  
PAYABLE

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

KB

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: *Glenda Coleman-Miller* Date: March 5, 2007

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: Joanna Pawlyshyn (Print name)	Title: V.P. & C.O.O.	Phone # 735-4101
(Signature) <i>[Signature]</i>	<i>Levelly</i>	Date
Approved By:	Title:	Phone #
(Signature)	<i>07 Nov 06</i>	Date

### NOTE:

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
- GST amounts included in the expense claims will be calculated by Accounts Payable.
- Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
- For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
- For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
- See page 2 of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP





From the desk of *Marg Zapf*

Attendees at Linda Keehn's Dinner (February 27, 2007)

- Keehn, Linda
- Pawlyshyn, Joanna
- Aguillon, Gail
- Armstrong, Marilyn
- Brady-Fryer, Barb
- Bremer, Ronna
- Coleman-Miller, Glenda
- Devlin, Maria
- Dickout, Bill
- Janes-Kelley, Selikke
- Lee, Karr-Ming
- MacVicar, Cindy
- Rees, Steve
- Stefaniuk, Lois
- Westwood, Wanda
- Yu, Rose
- Zapf, Marg

- Darda, Reverdi
- Davey, Doug
- Young, Susan

20 people



*RAM* *Lenin*

*at Jean.*

APPLICANT COPY

CHARACTERS REST  
10257 105 Street  
EDMONTON, AB.  
T5J 1E3  
(780) 421-4100  
GST# 89206-4429

CHARACTERS REST  
10257 - 105 STREET  
EDMONTON, AB.  
T5J 1E3

780-421-4100  
GST# 89206-4429

Date: Feb 27 '07 08:46PM  
Card Type: M/C  
Acct #:   
Exp Date:   
Auth Code: 035743  
Check #: 7604  
Table: 101/1  
Server: 110 SNOW S  
GLENDA COLEMAN-MILLER

Subtotal: 2087.86

GRATUITY

TOTAL

SIGNATURE

\*\* Merchant Copy \*\*

110 SNOW S

Tbl 101/1 Chk 7604 Gst 19  
Feb 27 '07 07:36PM

19 @ 63.00  
SET MENU \$63 1197.00  
half MEAL

s.17(1), 17(4)(e.1)

1 JFEN \*\*\* ENTREE 20.00  
2 @ 40.00  
B.FACELLI FUME 80.00  
2 @ 44.00  
1.WOLF BLSSCHARD 88.00  
7 B.BRUSSET @ 36.00 252.00  
17 COFFEE @ 2.75 46.75  
18 %

Gratuity 16% 303.08

Subtotal 1683.75  
Service Charge 303.08  
GST 101.03

08:36 Amount D 2087.86

WELCOME TO CHARACTERS!  
& HAVE A GREAT DAY!!



**APPLICANT COPY**  
**Travel & Employee Expense Claim Form**  
*(In Canadian Dollars)*

s.17(1), 17(4)(g)(i)

<b>Name:</b> Glenda Coleman-Miller	<b>Employee Number:</b>	<b>Union Name:</b>
<b>Position:</b> Senior Operating Officer		<b>Department:</b> RAH - Executive
<b>Business Phone:</b> 735-5271	<b>Period From:</b> Feb. 2 to Feb. 2, 2007	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included	
201	9000	71110601001	62414000			\$318.00	<input checked="" type="checkbox"/>	
							<input type="checkbox"/>	
							<input type="checkbox"/>	
							<input type="checkbox"/>	
							<input type="checkbox"/>	
							<input type="checkbox"/>	
							<input type="checkbox"/>	
<b>Less Cash Advance</b>							<input type="checkbox"/>	
<b>Total</b>							\$318.00	<input checked="" type="checkbox"/>

Capital Health  
**RECEIVED**  
 MAR 19 2007  
 ACCOUNTS  
 PAYABLE

①

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

**Employee Signature:** *Glenda Coleman-Miller*      **Date:** February 28, 2007

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

<b>Approved By:</b> (Print name) <i>Gail Hufty</i>	<b>Title:</b> <i>Acting Director, Quality</i>	<b>Phone #</b> <i>735-0768</i>
<b>(Signature)</b> <i>Gail Hufty</i>		<b>Date</b> <i>Mar 1/07</i>
<b>Approved By:</b> (Print name) <i>Donna Towers</i>	<b>Title:</b> <i>VP &amp; CLO</i>	<b>Phone #</b>
<b>(Signature)</b> <i>Donna Towers</i>		<b>Date</b>

**NOTE:**

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
- GST amounts included in the expense claims will be calculated by Accounts Payable.
- Fully completed Travel & Employee Expense Claim forms received in Accounting Services by **Thursday, 4:00 p.m.** will be processed the following week.
- For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
- For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
- See page 2 of this form for expense claim limits.
- Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
- Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

**EXPENSE CLAIM COPY**

**Recommended Coding**

- Local Travel – Staff - 62410000
- Staff Local Travel – Taxi – 62410001
- Staff Travel – UKA – 62410002
- Staff Provincial Travel – 62412000 (all expenses)
- Staff Out of Province Travel – 62414000 (all expenses)
- Catering – 69600000
- Meals - 62410000
- Mileage – 62410000
- Course Registration & Materials – 61030000

Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
Feb. 2/07	Re-imburement for Registration - SHN Conference - Montreal			\$318.00			
<b>Total km</b>							
<b>Rate as outlined in Section 2 – Travel below @</b>							
<b>Totals</b>				\$318.00			

**EXPENSE LIMITS**

**1. Meal Allowances**

When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:

- Breakfast \$8.50 (if the departure time is earlier or the return time is later than 7:30 a.m.)
- Lunch \$10.75 (if the departure time is earlier or the return time is later than 1:00 p.m.)
- Dinner \$19.20 (if the departure time is earlier or the return time is later than 6:30 p.m.)

For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.

Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.

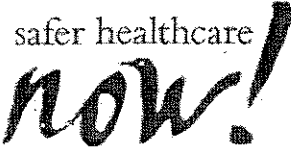
**2. Travel**

- Use of personal automobile – From March 1, 2006, reimbursement at the general rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
- Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
- Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
  1. Monthly travel in excess of 340 kilometers; or
  2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
  3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
- If union contract rate differs from \$0.43 then contract rate must be used.
- Includes all forms of transportation costs, including taxis and buses for local travel.
- Driving to and from work is not considered business travel and cannot be claimed.

**3. Advance**

Travel advance may be requested provided travel expenses are likely to exceed \$500.

APPLICANT COPY



Safer Healthcare Now! Learning Series IV  
 March 27 to 28, 2007  
 Le Centre Sheraton Montréal Hotel

**RECEIPT**  
 GST # 86867 4003 RT 0001

Date	Receipt No.
02/02/2007	S000001

**Payer:**

Glenda Coleman-Miller  
 Royal Alexandra Hospital  
 10240 Kingsway Avenue  
 Edmonton, AB T5H 3V9

Inv No.	Description	Total Fees	Tax	Applied Amount
S0000004	Registration for Glenda Coleman-Miller to attend: <i>Safer Healthcare Now! Learning Series IV</i>	\$300.00	\$18.00	\$318.00
		<b>GST = \$18.00</b>	<b>Total Fees w/Tax</b>	\$318.00
Visa:		<b>Total Paid</b>		\$318.00
s.17(1), 17(4)(e.1)		<b>Total Applied</b>		\$318.00
		<b>Unapplied Balance</b>		0.00

Thank you for your payment received on 02/02/2007.

Note: If you paid by credit card, your statement will read **BUKSA Assoc. (780) 436-0983 Edm.**

**Safer Healthcare Now! Learning Series IV**  
 c/o BUKSA Conference Management and Program Development  
 Suite 307, 10328 - 81 Avenue NW Edmonton AB T6E 1X2  
 Phone: (780) 436-0983 ext. 229 Fax: (780) 437-5984 E-mail: shn@BUKSA.com

APPLICANT COPY

BUKSA ASSOCIATES  
SUITE 307, 10328-81 AVE  
EDMONTON AB

s.17(1), 17(4)(e.1)

CARD  
CARD TYPE VISA  
DATE 2007/02/02  
TIME 0511 12:27:26  
RECEIPT NUMBER  
M34537508-001-201-001-0

PURCHASE  
TOTAL-CAD

**\$318.00**

**APPROVED**

AUTH# 017715 01-027  
THANK YOU

CARDHOLDER COPY





s.17(1), 17(4)(g)(i)

# APPLICANT COPY Travel & Employee Expense Claim Form (In Canadian Dollars)

Reimbursed - 29 Mar 07.  
Mar 26 - 29 / 07  
Montreal

Name: Glenda Coleman-Miller.	Employee Number:	Union Name:
Position: Senior Operating Officer	Department: RAH - Exec	
Business Phone: 735-5272	Period From: March 25 to March 29, 2007	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	9000	71110601001	62414000			\$859.43	<input checked="" type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
Total						\$859.43	<input checked="" type="checkbox"/>

Capital Health  
**RECEIVED**  
APR 26 2007  
ACCOUNTS  
PAYABLE

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: Glenda Coleman-Miller Date: Apr. 5/07

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: (Print name) <u>Gail Hyftly</u>	Title: <u>Acting Director, Regional Quality</u>	Phone # <u>735-0768</u>
(Signature) <u>Gail Hyftly</u>		Date <u>April 11/07</u>
Approved By: (Print name) <u>Danna Towers</u>	Title: <u>VP &amp; CLO</u>	Phone # <u>735-0675</u>
(Signature) <u>Danna Towers</u>		Date <u>April 13/07</u>

- NOTE:
- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
  - GST amounts included in the expense claims will be calculated by Accounts Payable.
  - Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
  - For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
  - For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
  - See page 2 of this form for expense claim limits.
  - Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
  - Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP



APPLICANT COPY



**Le Centre Sheraton**

H Ô T E L  
M O N T R É A L

1201 BOUL RENÉ-LEVESQUE OUEST, MONTRÉAL, QUÉBEC, CANADA H3B 2L7 TÉL [514] 878-2000 FAX [514] 878-3958 SHERATON.COM/LECENTRE

**N  
O  
M**  
Mrs Glenda Coleman-miller  
Royal Alexander Hospital  
10240 Kingsway  
Edmonton, AB T5H 3B9  
Canada  
PSI3E

CHAMBRE 1818  
TARIF 159.00  
NO. PERS. 1  
FOLIO 395293 EX-A  
PAGE 1  
ARRIVEE 25-MAR-07 19:24  
DEPART 29-MAR-07  
PAIEMENT VI

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DATE	REFERENCE	DESCRIPTION	DEBIT CREDIT
25-MAR-07		Non-Responsive	
25-MAR-07			
25-MAR-07			
25-MAR-07	RT1818	Frais Chambre/Room Charge	159.00
25-MAR-07	RT1818	Taxe Touristique	4.77
25-MAR-07	RT1818	TPS/GST 6%	9.83
25-MAR-07	RT1818	TVQ/PST 7.5%	13.02
25-MAR-07			
25-MAR-07		Non-Responsive	
25-MAR-07			
26-MAR-07	RT1818	Frais Chambre/Room Charge	159.00
26-MAR-07	RT1818	Taxe Touristique	4.77
26-MAR-07	RT1818	TPS/GST 6%	9.83
26-MAR-07	RT1818	TVQ/PST 7.5%	13.02
26-MAR-07	13173520	Casual Restaurant	20.00
26-MAR-07	13173520	TPS/GST- 6.0%	1.02
26-MAR-07	13173520	TVQ/PST- 7.5%	1.36
27-MAR-07	RT1818	Frais Chambre/Room Charge	159.00
27-MAR-07	RT1818	Taxe Touristique	4.77
27-MAR-07	RT1818	TPS/GST 6%	9.83
27-MAR-07	RT1818	TVQ/PST 7.5%	13.02
27-MAR-07	461A	0006 12:41 s.17(1), 17(4)(g)(i)	1.49
27-MAR-07	461A	Tax - GST Other	0.09
27-MAR-07	461A	Tax - PST Other	0.12
27-MAR-07			
27-MAR-07		Non-Responsive	
27-MAR-07			
28-MAR-07	RT1818	Frais Chambre/Room Charge	159.00
28-MAR-07	RT1818	Taxe Touristique	4.77
28-MAR-07	RT1818	TPS/GST 6%	9.83
28-MAR-07	RT1818	TVQ/PST 7.5%	13.02

\*\* continued on the next page \*\*

Je consens et m'engage personnellement à payer ce compte si l'entreprise ou tout autre tierce partie facturée omet de payer les montants dûs en tout ou en partie.  
I agree to remain personally liable for the payment of this account if the corporation or other third party billed fails to pay part or all of these charges.

signature

Mrs Glenda Coleman-miller  
FOLIO 395293 25-MAR-07

MEMBRE DE  STARWOOD PREFERRED GUEST

APPLICANT COPY



**Le Centre Sheraton**

HÔTEL  
MONTREAL

1201 BOUL. RENÉ-LEVESQUE OUEST, MONTRÉAL, QUÉBEC, CANADA H3B 2L7 TÉL [514] 878-2000 FAX [514] 878-3958 SHERATON.COM/LECENTRE

<b>N O M</b>	Mrs Glenda Coleman-miller	CHAMBRE	1818		<b>A G E N C E D E  C H A R G E R À</b>
		TARIF	159.00		
		NO. PERS.	1		
	Royal Alexander Hospital	FOLIO	395293	EX-A	
	10240 Kingsway	PAGE	2		
	Edmonton, AB T5H 3B9	ARRIVEE	25-MAR-07	19:24	
	Canada	DEPART	29-MAR-07		
	PSI3E	PAIEMENT	VI		

DATE	REFERENCE	DESCRIPTION	DEBIT CREDIT
29-MAR-07	VI	Visa	934.16-
		Total Charges	<del>934.16</del>
		Total Credits	<del>934.16</del>
		Balance Due	0.00

Afin de mieux vous servir, nous avons imprimé ce folio comme solde. Quoique ce folio présente un solde de zéro, il est possible que des opérations supplémentaires ne soient imputées qu'après votre départ. Nous tenons à vous informer que toutes ces éventuelles opérations seront soldées par la carte de crédit présentée lors de votre enregistrement à l'hôtel. Il est de votre responsabilité d'acquitter l'ensemble des opérations portées sur votre folio

770.56

For your convenience, we have prepared this zero-balance folio indicating a \$0 balance on your account. Please be advised that any charges not reflected on this folio will be charged to the credit card on file with the hotel. While this folio reflects a \$0 balance, your credit card may not be charged until after your departure. You are ultimately responsible for paying all of your folio charges in full.

\*\* continued on the next page \*\*

Je consens et m'engage personnellement à payer ce compte si l'entreprise ou tout autre tierce partie facturée omet de payer les montants dus en tout ou en partie. I agree to remain personally liable for the payment of this account if the corporation or other third party billed fails to pay part or all of these charges.

signature

Mrs Glenda Coleman-miller  
FOLIO 395293 25-MAR-07  
MEMBRE DE STARWOOD PREFERRED GUEST

HMS HOST  
MONTREAL  
AEROPORT MONTR.

3096 Alba

1 29 11 8915 GST 1  
29 MAR '07 8:55

TAXI NEMIRAK LAFLEUR 363-5111  
TAXI HENRIK HENLOCK LUXE 931-6666  
TAXI HENRIK HENLOCK 161-1666

29-03-07 \$ 40

DATE:

DE/FROM:

AUTO: 3381

N° Vignette / Cum No. 24693 N° permis de travail / Work permit No

NIP:

Signature du conducteur / Driver's signature

Signature du client / Customer's signature 1070375



Taxi Para-Adapté pour personne en fauteuil roulant

- Transport médical
- Transport en accompagnement
- Transport pour hémodyalise

277-3344



\*\*\* SIEGE 1 \*\*\*  
1 2 Oeufs 5.99  
ROTIES ANC  
JAMBON  
1 CAFE 1.79  
CAFE  
Sous-Total 7.78  
7.78 T.P.S. 217101 0.47  
8.25 T.V.Q. 217010 0.62  
Montant \$ 8.87  
\*\*\*\*\*  
\*\*\*\*\*

Sous-Total 7.78  
7.78 T.P.S. 217101 0.47  
8.25 T.V.Q. 217010 0.62  
Montant Du \$ 8.87

APPLICANT COPY

\*\*\*\*\*  
MONTREAL EN SCENE  
IPS R137512901  
TVQ 1019856077  
S.V.P. PAYEZ AU SERVEUR  
\*\*\*\*\*  
\*\*\*\*\*

\*\*\* S.v.P. Payez au Serveur \*\*\*  
\*\*\* Merci de votre Visite \*\*\*  
\*\*\* A La Prochaine \*\*\*  
\*\*\* SERVICE NON COMPRIS \*\*\*\*  
\*\*\* TIPS NOT INCLUDED \*\*\*\*

Date 26/03/09  
Montant Amount 40  
Départ Departure  
A To  
Auto No Car  
Chauffeur Driver 7174  
Vignette No 24693  
-le Travail



APPLICANT COPY

Travel & Employee Expense Claim Form

(In Canadian Dollars)

s.17(1), 17(4)(g)(i)

Name: Glenda Coleman-Miller	Employee Number:	Union Name:
Position: Senior Operating Officer	Department: Exec	
Business Phone: 735-5271	Period From: April 18 to April 18, 2007	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0002	71110101001	62410000	6960000		\$298.07	<input checked="" type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
Total						\$298.07	<input checked="" type="checkbox"/>

Capital Health Authority  
**RECEIVED**  
MAY 04 2007  
ACCOUNTS PAYABLE

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: *[Signature]*

Date: 01-MAY-07

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: Joanna Pawlyshyn (Print name)	Title: V.P. & C.O.O.	Phone # 735-4101
(Signature) <i>[Signature]</i>	01 May 07	Date
Approved By: (Print name)	Title:	Phone #
(Signature)		Date

NOTE:

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
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- Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP



APPLICANT COPY

*Thank you very much!*

*Denise C  
Ambulatory  
Care candidate  
Joanna + Dr. D.*

THANK YOU FOR JOINING US  
AT SORRENTINOS  
G.S.T.#829541298

11 TOBY

TBL 17/1      CHK 830      GET 4  
APR18'07 06:14PM

Net Charge: 187.50  
Term: 01/4652055  
Employee ID: 11

Pre-Auth

MASTERCARD  
Type: 0000000000000000      Serial: 18700100211  
s.17(1), 17(4)(e.1)  
Amount: \$ 268.07  
Tip: \$ 30.00  
**Total: \$ 298.07**

2 GF GL.RED	16.00
2 GLS.BARCO REALE	24.00
3 GF GL.WHITE	24.00
2 PANNA MIN.WATER	13.90
2 GF EN CROUTE	24.00
1 GF PRAWNS	13.00
1 GF SOUP	7.00
2 GF ARTIC CHAR	64.00
2 GF CHICKEN	54.00
1 GELATO	7.50
VANILLA	
1 .TEA	2.75
1 COFFEE	2.75
SUBTOTAL 252.90	
G S T	15.17
<b>TOTAL DUE</b>	<b>268.07</b>

001/ APPROVED 015561  
18-Apr-07      20:16:01  
Customer Copy  
SORRENTINO'S GIFT CARDS ARE NON-REFUNDABLE

PLEASE PAY SERVER  
THANK - YOU





# APPLICANT COPY

## Travel & Employee Expense Claim Form

(In Canadian Dollars) 17(1), 17(4)(g)(i)

Name: Glenda Coleman-Miller	Employee Number:	Union Name:
Position: Senior Operating Officer	Department: Exec	
Business Phone: 735-5271	Period From: April 26 to April 29, 2007	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0002	71110101001	62414000			\$838.65	<input checked="" type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
<b>Total</b>						\$838.65	<input checked="" type="checkbox"/>

Capital Health Authority  
**RECEIVED**  
 MAY 04 2007  
 ACCOUNTS  
 PAYABLE

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: *Glenda Coleman-Miller* Date: *01-May-07*

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: Joanna Pawlyshyn (Print name)	Title: V.P. & C.O.O.	Phone # 735-4101
(Signature) <i>[Signature]</i>	<i>01 May 07</i>	Date
Approved By:	Title:	Phone #
(Signature)		Date

- NOTE:**
- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
  - GST amounts included in the expense claims will be calculated by Accounts Payable.
  - Fully completed Travel & Employee Expense Claim forms received in Accounting Services by Thursday, 4:00 p.m. will be processed the following week.
  - For all employees on the payroll system, expense reimbursements will be deposited to employee bank account.
  - For physicians, contracted employees and those not paid through the payroll system, expense reimbursements will be mailed through the internal mail system.
  - See page 2 of this form for expense claim limits.
  - Approved claim form with receipts should be sent to Accounts Payable (Capital Health Centre, North Tower - 10<sup>th</sup> Fl., 10030 - 107 Street, Edmonton, AB T5J 3E4)
  - Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP

## EXPENSE CLAIM FORM

### Recommended Coding

- Local Travel – Staff - 62410000
- Staff Local Travel – Taxi – 62410001
- Staff Travel – UNA – 62410002
- Staff Provincial Travel – 62412000 (all expenses)
- Staff Out of Province Travel – 62414000 (all expenses)
- Catering – 69600000
- Meals - 62410000
- Mileage – 62410000
- Course Registration & Materials – 61030000

Date	Particulars (Describe Purpose of Trip & Location)	Accomm. \$	Meals	Course Registration & Materials	Transportation \$	Other	Mileage km
April 26/07	ACEN Conference - Toronto Taxi - Airport to Hotel - Toronto				\$52.00		
April 29/07	Taxi - Hotel to Airport - Toronto				50.00		
April 29/07	Car Park - Edm. Airport				34.00		
April 26-29/07	Metropolitan Hotel Toronto - Includes Room Service, Internet Access	612.18	70.03			20.44	
<b>Total km</b>							
<b>Rate as outlined in Section 2 – Travel below @</b>							
<b>Totals</b>		\$612.18	\$70.03		\$136.00	20.44	\$838.65

### EXPENSE LIMITS

**1. Meal Allowances**

When traveling on Capital Health business, the employee may be reimbursed at the Per Diem meal allowance of:

- Breakfast     \$8.50 (if the departure time is earlier or the return time is later than 7:30 a.m.)
- Lunch         \$10.75 (if the departure time is earlier or the return time is later than 1:00 p.m.)
- Dinner        \$19.20 (if the departure time is earlier or the return time is later than 6:30 p.m.)

For meal expenses that exceed the above amounts, the supervisor may approve higher amounts, with receipts, provided these are reasonable.

Meal expenses must be supported by restaurant receipt (not just credit card receipt) and information on either the names of the individuals or organizations whose representatives attended the lunch/dinner meeting.

**2. Travel**

- Use of personal automobile – From March 1, 2006, reimbursement at the general rate of \$0.43 per km for the first 15,000 kilometers of approved travel in a fiscal year (April 1 to March 31) and \$0.40 for each kilometer there after (except where collective agreement specifies otherwise).
- Business car insurance is reimbursable up to \$260 per year with receipts in accordance with Capital Health Policy.
- Effective March 1, 2006, out of scope employees required to provide a vehicle as a condition of employment and meeting the following requirements on a regular and continuing basis as approved by an authorized manager.
  - 1. Monthly travel in excess of 340 kilometers; or
  - 2. Monthly expense equivalent to four (4) return cab fares at \$20 one way; or
  - 3. Daily requirements to utilize personal vehicle in the course of duties – reimbursed at \$0.50 per kilometer.
- If union contract rate differs from \$0.43 then contract rate must be used.
- Includes all forms of transportation costs, including taxis and buses for local travel.
- Driving to and from work is not considered business travel and cannot be claimed.

Guest Signature

PAGE 1

29APR, 07

Glenda Coleman-Miller  
Academy of Cdn Exc Nurses  
Royal Alexandra Hospital  
c/o 10240 Kings Way  
Edmonton, Ab  
T5H 3V9

Ar/#N/Dp 26APR, 07/ 3/29APR, 07

Folio# 013113  
Ck-Out 29APR, 07 7:50a IR

FT2

L#	Date	Cx/Room	Description	Reference	Amount	V	ID
001	26APR	1 /1423	Room Service	9947	35.35+		
002	26APR	1 /1423	GST-Room Service	9947	1.74+	F	
003	26APR	1 /1423	PST-Food Rm Serv	9947	1.36+	X	
004	26APR	1 /1423	PST-Bev Rm Serv	9947	1.20+	X	
005	26APR	1 /1423	Group Room	Rm 1423	179.00+		NA
006	26APR	1 /1423	PST-Room	Rm 1423	8.95+	R	NA
007	26APR	1 /1423	GST-Room	Rm 1423	10.74+	A	NA
008	26APR	1 /1423	DMF	Rm 1423	5.37+		NA
009	27APR	1 /1423			<del>5.37+</del>		
010	27APR	1 /1423			<del>5.37+</del>	F	
011	27APR	1 /1423			<del>5.37+</del>	X	
012	27APR	1 /1423	Internet Access	000-000-0000 L	10.22+		T
013	27APR	1 /1423	Room Service	33	27.30+		
014	27APR	1 /1423	GST-Room Service	33	1.32+	F	
015	27APR	1 /1423	PST-Food Rm Serv	33	1.76+	X	
016	27APR	1 /1423			<del>5.37+</del>		
017	27APR	1 /1423	Group Room	Rm 1423	179.00+		NA
018	27APR	1 /1423	PST-Room	Rm 1423	8.95+	R	NA
019	27APR	1 /1423	GST-Room	Rm 1423	10.74+	A	NA
020	27APR	1 /1423	DMF	Rm 1423	5.37+		NA
021	28APR	1 /1423	Internet Access	000-000-0000 L	10.22+		T
022	28APR	1 /1423	Group Room	Rm 1423	179.00+		NA
023	28APR	1 /1423	PST-Room	Rm 1423	8.95+	R	NA
024	28APR	1 /1423	GST-Room	Rm 1423	10.74+	A	NA
025	28APR	1 /1423	DMF	Rm 1423	5.37+		NA
026	29APR	1 /1423	VISA	Express Checkout	<del>714.01</del>		IR

~~701.75~~  
702.65

BALANCE .00

GST#	NET AMOUNT	GST	PST	GROSS AMOUNT
R136359494				
A 0.0000	Room GST	.00	32.22+	32.22+
F 0.0000	F&B GST	.00	3.57+	3.57+
R 0.0000	Room PST	.00	26.85+	26.85+
T 6.0000	Telephone	20.70+	1.24+	21.94+
X 0.0000	F&B PST	.00	5.17+	5.17+
	624.26+			624.26+ SUBTT
TOTAL	644.96+	37.03+	32.02+	714.01+

# EDMONTON AIRPORTS

GST# R12859778

\*\*\*\*\*

Car park 0006301300 Phone: (780) 890-8439  
 Fax: (780) 890-8329

Receipt no. 0172/0/89/00892 29.04.07

015:00 pay parking ticket 34,00 \$  
 29.04.07 09:50 - 29.04.07 13:03  
 length of stay: 3 Dy, 3 Hr, 13 Min.

**total amount 34,00 \$**

accepted total 34,00 \$  
 G.S.T. 6,00 \$ 1,92 \$

Thank you for your patronage!  
 Please Come Again!  
 \*\* Open 24 hours \*\*  
 \*\* Thank you \*\*

APPLICANT COPY

EDMONTON AIRPORTS SERVICE AUTH  
 416 MILLER AVE. W. AIRP  
 EDMONTON  
 S17(1), 17(4)(c.1)

0172/0/89/00892

0172/0/89/00892

DATE: 29.04.07  
 TIME: 13:03:34  
 VISA  
 2169  
 29.07/04/29 13:03:34  
 50059 5017 905-075

total amount 434.06

0172/0/89/00892 AUTH. # 099902  
 Thank you!

EDMONTON AIRPORTS SERVICE AUTH  
 416 MILLER AVE. W. AIRP  
 EDMONTON

G COLEMAN MILLER

MERCHANT COPY



**416-366-6868**  
 www.diamonntaxi.ca

DATE: Apr 29 30 AMT. \$ 50  
 FROM: Mr Port  
 TO: Mr Port  
 DRIVER'S NAME: Mr Port  
 CAB# 2222 FARE INCLUDES GST  
 The driver is an Independent Contractor, any GST input credit may be claimed as "notional" or applied to the driver's GST registered number, not Diamond Taxi Inc.  
 THANK YOU

CAR NO.: HIP to GST  
 DATE: 26/4/07  
 AMOUNT PAID: 50  
 DRIVER: [Signature]  
 Thanks



# APPLICANT COPY

## Travel & Employee Expense Claim Form

(In Canadian Dollars)

s.17(1), 17(4)(g)(i)

Name: Glenda Coleman-Miller	Employee Number:	Union Name:
Position: Senior Operating Officer	Department: Executive	
Business Phone: 735-5271	Period From: June 27 to June 27, 2008	

Expenses Paid (please attach receipts). Do not include amounts paid by Capital Health or reimbursed / reimbursable by another organization. Complete details on the other side of the form

Bal Unit e.g. 201	Location e.g. 9000	Functional Centre e.g. 71135050044	Account e.g. 69500001	Non-Canadian Currency	Rate	Canadian \$ (including GST)	✓ if GST included
201	0002	711101001	62410000			\$100.00	<input checked="" type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>
Less Cash Advance							<input type="checkbox"/>
<b>Total</b>						<b>\$100.00</b>	<input checked="" type="checkbox"/>

Capital Health  
**RECEIVED**  
JUL 14 2008  
**ACCOUNTS  
PAYABLE**

The information on this form is collected under section 4 of the Regional Health Authorities (Ministerial) Regulation and will be used to process your claim.

I hereby certify that the expenses listed above were incurred on Capital Health business and have not been previously claimed by me or on my behalf from Capital Health or other organization.

Employee Signature: *Glenda Coleman-Miller* Date: July 3, 2008

I hereby certify that I have reviewed the expenses and rate at which mileage is being claimed.

Approved By: Joanna Pawlyshyn <small>(Print name)</small>	Title: V.P. & C.O.O.	Phone # 735-4101
<small>(Signature)</small> <i>[Signature]</i>	10 Jul 08	Date
Approved By:	Title:	Phone #
<small>(Print name)</small>		
<small>(Signature)</small>		Date

**NOTE:**

- Expense claim must be properly authorized and must be supported by original receipts or a copy as certified by the approver. The approver must initial individual items that are not supported by original invoices or do not have all the required supporting documents to indicate approval without support. Unsupported claims over \$1,000 require Level 4 approval.
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- Out of province expenses require a Travel Approval Form (CH 198) in advance authorized by a COO or VP



APPLICANT COPY

File Copy

Jun 27, 2008  
11:44 AM

2409463  
KATRINA V

EvelineCharles Salons Spas  
Shop online at EvelineCharles.com!  
GLENDA COLEMAN-MILLER  
CLIENT # 10372311

Non-Responsive

Description	Each	Total
...Recommended by: JULIE T	\$17.00	\$17.00
...Recommended by: JULIE T	\$12.00	\$12.00
<del>Gift Card</del>	<del>\$100.00</del>	<del>\$100.00</del>
Sub-Total		\$129.00
GST		\$1.45
Shipping & Handling		\$0.00
Transaction Total		\$130.45

Description	Ref #	Value
VISA		\$130.45

Payment Total	\$130.45
Change Due	\$0.00

Your Next Appointment Is...  
Tue, Jul 8, 2008 @ 11:00 AM

Final sale items include Gift Cards, Gift Sets, Sale Items, Cosmetic Styling Tools and Cosmetic Brushes. EvelineCharles hair dryer and flat iron carry a 1 year limited warranty. Any other unused EvelineCharles product can be returned for an exchange or credit within 14 days when accompanied with the receipt.

GST #13639 6710 RT0001

Client Copy