EXPENSE CLAIM

with supporting documentation

Date: _____

International Neuroinformatics
Coordinating Facility
Karolinska Institutet

All information is mandatory

KI employee: YES ☐ NO ☐

Surname: _____
Name: _____
Street Address: _____
Post Code & City: _____
Birth country & Region: _____
Date of Birth(YYYY-MM-DD): _____
Tax Residency: _____
TAX-Number: _____
Phone Number: _____
Email-Adress: _____

Meeting/Workshop: _____

Role: _____

Start date(YYYY-MM-DD): _____
End Date(YYYY-MM-DD): _____

Amount: _____ **Currency:** _____

Signature: _____

INCF

Authorized signature: _____
Short-code: _____