STATE OF NEW HAMPSHIRE
Honorarium or Expense Reimbursement Report (RSA 15-B)

Type or Print all Information Clearly:

Name: ARTHUR (First) D (Middle) MCKIBBIN (Last) Work Phone No. 603-359-7420

Work Address: 3 BAY DRIVE ENFIELD, NH 03748

Office/Appointment/Employment held: BOARD MEMBER ; BOARD OF DENTAL EXAMINERS

List the full name, post office address, occupation, and principal place of business, if any, of the source of any reportable honorarium or expense reimbursement. When the source is a corporation or other entity, the name and work address of the person representing the corporation or entity in making the honorarium or expense reimbursement must be provided in addition to the name of the corporation or entity.

Source of Honorarium or Expense Reimbursement:

Name of source: (First) (Middle) (Last)

Post Office Address:

Occupation:

Principal Place of Business:

RECEIVED
NOV 07 2017
NEW HAMPSHIRE
DEPARTMENT OF STATE

If source is a Corporation or other Entity:

Name of Corporation or Entity: CDCA

Name of Corporate/Entity Representative: MR. JACK FELDSMAN

Work Address of Representative: PO Box 34781 BETHESDA, MD 20827

Food and/or beverages consumed pursuant to RSA 15-B:6, II with **value over $25.00** ☐

Value of Honorarium: $1,150 - Date Received: 10/18/17 ***If exact value is unknown, provide an estimate of the value of the gift or honorarium and identify the value as an estimate.*** ☒ Exact ☐ Estimate

Value of Expense Reimbursement: $693.52 Date Received: 10/18/17 ***A copy of the agenda or an equivalent document must be attached to this filing.*** ☒ Exact ☐ Estimate

Briefly describe the service or event this Honorarium or Expense Reimbursement relates to:

GRADING MANIKINS FOR ADEX PRE-LICENSING EXAMS

"I have read RSA 15-B and hereby swear or affirm that the foregoing information is true and complete to the best of my knowledge and belief."

Signature of Filer — 11/2/17 Date Filed

9/07

RSA 15-B:9 Penalty. Any person who knowingly fails to comply with the provisions of this chapter or knowingly files a false report shall be guilty of a misdemeanor.

Return to: Secretary of State's Office, State House Room 204, Concord, NH 03301

THE COMMISSION ON DENTAL COMPETENCY ASSESSMENTS

Expense Reimbursement and Honorarium Request Form

THE COMMISSION ON DENTAL COMPETENCY ASSESSMENTS

Name: ARTHUR M'KIBBIN

Examiner#: 51241
Leave blank if not a CDCA Examiner

Address: 3 BAY DRIVE

Address:

City: ENFIELD

State: NH Zip: 03748

Phone #: 603-359-7420

Email: admckibbin@gmail.com

What is the purpose of this reimbursement? (Only one examination or meeting per Request Form):

Exam: MAIN OFFICE (Indicate Site)

Meeting: (Indicate Committee or Organization)

Dates 9/13 - 9/15 2017 (Only Dates Attended (include calibration days))

Dates: (OnlyDatesAttended(include if travel day prior to meeting)

Type MANIKIN GRADING (Dental or Hygiene)

Purpose: (Describe)

350
400
400
1,150

Note - Examiner Honorariums will be included with your reimbursement according to this schedule: $400 per **Examination** Day, $350 per **Calibration** Day; $250 per **Meeting** Day; $100 for Travel Day to Meeting

	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Total	Account
Record Dates of Expense				9/13	9/14	9/15		Total	Account
Air (include receipt)				✓		✓		~~$277.96~~	5030
Rental Car (include receipt)								247.96	5031
Rental Car Fuel (include receipt)									5031
Rail (include copy of ticket)									5030
Personal Auto - Total Miles Here → 172				✓		✓		92.02	
Calculated @ $.53.5 per mile	0	0	0	0	0	0	0	0.00	5031
Taxi/van/bus/limo (include receipts)								~~$1.00~~	5031
Parking (include receipts)				✓	✓	✓		52.00	
Tolls				✓		✓		2.00	5031
Lodging (include hotel bill)				✓	✓	✓		291.54	5020
Misc. expenses (include receipts/explanation)				✓		✓		8.00	TIPS (CASH)
				350-	400-	400-		0.00	**TOTAL DUE**

YOU MUST SIGN/TYPE & DATE THIS FORM: ADMcKibbin DATE 9/26/2017

Email Form

Submit to the CDCA for reimbursement by sending to invoice@cdcaexams.org or by mailing to the CDCA at PO Box 34781, Bethesda, MD 20827. Please attach/include receipts.

THIS FORM MUST BE SUBMITTED TO THE CDCA WITHIN 30 DAYS OF YOUR TRAVEL

~~$1,872.52~~
$1,843.52

Questions? Contact the CDCA - Ms. Shirley Nolan at snolan@cdcaexams.org or Mr. Jack Feldesman at jfeldesman@cdcaexams.org