MILEAGE REIMBURSEMENT FOR LOCAL TRAVEL

UNION COUNTY PUBLIC SCHOOLS

HOSPITAL/HOME-BASED SERVICES

PAYEE INFORMATION

Name: _____

Home Address: _____

_____

School/Dept: _____

Position: _____

This is a true and accurate statement of expenses incurred in discharging official business duties.

_____

Signature

_____

Date

Date of Travel	From	To	Purpose	Miles

Original due to Accounts Payable by the 5th of each month w/proper signatures.

Please print name and address above. Travel Checks will be mailed to your home.

EC Program Director _____

Budget Code _____

Vendor # _____

Total Miles _____

Mileage Rate X _____

Reimbursement Amount _____

Ck # _____ Ck Date_____

I certify the above expenses incurred are necessary and proper, and amounts claimed are just and reasonable.

Approved By _____

Principal/Department Head

This instrument has been preaudited in the manner required by the School Budget and Fiscal Control Act.

_____ _____

Finance Officer/Designee Date