REIMBURSEMENT FORM

Please note: This completed and signed form should be submitted to the ADMIN Office within 30 calendar days after event. For budget reasons, forms submitted after that may not be paid.

NAME OF PAYEE:	DEPARTMENT:

DETAILED EXPENDITURES *(OTHER THAN MILEAGE)*						MILEAGE REIMBURSEMENT				
NAME OF RETAILER	CONF. FEES	TRAVEL EXPENSE	SUPPLIES	TOTAL CLAIMED	PO#	BETWEEN WHAT POINTS FROM	TO	MILEAGE DRIVEN	RATE PER MILE	TOTAL MILEAGE REIMB.
									$0.51	
									$0.51	
									$0.51	
									$0.51	
									$0.51	
									$0.51	
									$0.51	
									$0.51	
									$0.51	
									$0.51	
									$0.51	
									$0.51	
									$0.51	
									$0.51	
									$0.51	
									$0.51	
									$0.51	
TOTALS						TOTAL FOR MILEAGE			$0.51	

SUB-TOTAL _____

MILEAGE CLAIMED _____

TOTAL CLAIMED _____

_____ Signature of Approving Supervior

_____ Signature of Person Being Reimbursed

_____ Date Approved

_____ Date Submitted