Travel Reimbursement Request Form

Submit to: College of Health Sciences
Program in Public Health 101Theory Suite 250

Please PRINT clearly Date _____

Account Name or Account Fund to be Charged: _____

Traveler Name: _____

Address: _____
street address *apt #*

_____
city *state* *zip* *daytime phone #*

Social Security #: _____ - ____ - _____ Email address _____
(SS# required for non-UC employees only)

U.S. Citizen ☐ Yes ☐ No U.C.I. Employee I.D. # **09** _____

Date & Time Left Home: _____ **AM/PM** **Date & Time Returned home:** _____ **AM/PM**

Destination & Purpose of Trip: _____

SUMMARY OF EXPENSES

Airfare: _____
Car Rental: _____
Registration Fees: _____

If Mileage is Being Claimed
License Plate #: _____
Is there liability Insurance for this vehicle/driver?
☐ Yes ☐ No

** List amounts for **each** day in appropriate column outlined below

**Date	City	Meals & Incidentals * see back page for amts	Hotel	Phone	Mileage $0.485/mile	Taxi/Bus	Other (explain)	TOTAL
TOTAL								

Explanation/Remarks: _____

Total amount to be reimbursed: _____
or Total amount to credit corportate card: _____

The above is a true statement of travel expenses incurred by me on official University business on the date(s) shown.

Traveler's Signature

Authorized Signature for fund source

Preparer's name

ORIGINAL RECEIPTS ARE REQUIRED AT ALL TIMES
Please tape receipts to 8 1/2 x 11 sheet of paper. Please do NOT staple.