SANTA PAULA UNIFIED SCHOOL DISTRICT

TRAVEL EXPENSE REPORT (TER)

List ONLY expenses paid by employee

NAME:_____SITE:_____

Name of conference or workshop: _____

Date: _____ Place: _____

REQUIREMENTS:
1. *Reimbursement cannot be made without itemized receipts*
2. *Please submit within ten (10) days of travel*
3. *Reimbursement checks will be sent to school/site*

GIVE DATE(S) OF FIRST AND LAST DAYS ONLY.	SUN	MON	TUE	WED	THUR	FRI	SAT	WEEKLY TOTAL BY ITEM(S)
LODGING								
MEAL(S) ($50 PER DAY)								
AIR/SHUTTLE/ BUS/TAXI								
MILEAGE (57.5.0¢ PER MILE) Attach Map to verify								
PARKING								
DAILY TOTALS								

DATE Processed: _____ **AMOUNT REIMBURSED TO EMPLOYEE:** $_____

_____   _____
Employee's Signature   Date   Site Administrator Signature   Date

Account number/s to be charged:_____

Account number/s to be charged:_____

Account number/s to be charged:_____

_____   _____
Approval by Budget Authority   Date   Assistant Supt./Business Services   Date

BUSINESS OFFICE USE ONLY		**AMOUNTS**
Encumbered Date: _____	P.O.#_____	_____
_____	P.O.#_____	_____
_____	P.O.#_____	_____
_____	P.O.#_____	_____