LAURENS COUNTY DISABILITIES AND SPECIAL NEEDS BOARD

Mileage & Meal Reimbursement Form

Employee Name: _____
For the Month of: _____
Department: _____

					Amount Requested				
Date	Time of Departure	Time of Return	Purpose of Travel	Destination	Mileage	Breakfast	Lunch	Supper	Other*
				Subtotal					
				Mileage X	Current IRS Rate				
				Totals	$	$	$	$	$
					Total Reimbursement (sum all amt columns)				$

*Other should be described out to the side of the column

I HERBY AUTHORIZE THE PAYMENT OF THE ABOVE REQUESTED REIMBURSEMENT AND VERIFY THAT ALL RECEIPTS ARE ATTACHED AS REQUESTED. ALSO, I AM APPROVING THAT THE MILEAGE ABOVE WAS A DIRECT RESULT OF NO AGENCY VEHICLE BEING AVAILABLE FOR THE EMPLOYEE TO USE.

EMPLOYEE SIGNATURE / DATE

SUPERVISOR SIGNATURE / DATE

ALL RECEIPTS MUST BE ATTACHED BEFORE PAYMENT WILL BE MADE.