

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:
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DETAILED EXPENDITURES (<i>OTHER THAN MILEAGE</i>)						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	
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									\$0.51	
									\$0.51	
									\$0.51	
									\$0.51	
TOTALS						TOTAL FOR MILEAGE			\$0.51	

Signature of Approving Supervisor	Signature of Person Being Reimbursed	SUB-TOTAL _____ MILEAGE CLAIMED _____ TOTAL CLAIMED _____
Date Approved	Date Submitted	