

Participant Mileage Reimbursement Request

Month:	Year:		
Participant Name:			
Address	City	Zip Code	

Please complete in ink. You may copy this form. Use the reverse or another sheet if necessary.

Date of Travel	Purpose of Travel	Beginning Mileage	Ending Mileage	Number of Miles	First 10 Miles Participant's	Miles to be Reimbursed
				Round Trip	Responsibility	
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					(-10)	
					(-10)	
			TOTAL		,	





^{**}The program reimbursement is for mileage costs directly related to attending classes. Other mileage is not eligible for reimbursement under this program. Mileage reimbursement is calculated at the rate of \$0.30 per mile after the first 10 miles traveled. There is \$150 monthly maximum and is based on funding availability.

checking my monthly a	ttendance records.				
STAFF USE ONLY:					
Total Miles x \$.30 (30 cents) /miletotal reimbursed *Maximum monthly reimbursement = \$150					
Amount Authorized	\$	Code			
Amount Authorized	\$	Code			
Amount Authorized	\$	Code			
Total Authorized:	\$				

I declare that this account of daily mileage traveled on page 1 is directly related to training and is true and accurate. I declare this under penalties of perjury. I understand my mileage can be verified by