

MILEAGE REIMBURSEMENT CLAIM FORM

Employee Name:		Employee ID:	Phone #:	
Location:	Department:		Position:	
Claim Month:	Year:		Account #:	

Date	Total Miles Driven	Check One		From:	To:	
		O/W	R/T	Name of Origin Street Address, City	Name of Destination Street Address, City	Purpose of Trip

Total Miles: _____ X ____ / Mile = _____

I have liability insurance on my automobile and agree to maintain insurance coverage as long as I use my automobile for school business. I hereby certify that the above mileage represents a true and accurate statement of actual and necessary expense and that I have not been reimbursed for the above total.

Claimant Signature

Administrator Signature

Audited by:

Accounting Department Signature