Employee / C	Claimant Informat	ion:						
Name:					Month:			
Address:						City/Zip:		
		elated expense incurred on beovers. The following procedu				the District form	n bearing the original	
or normal we	ork location. The sar	Oo not claim reimbursement fon ne applies to travel from wor Matrix to determine mileage,	k to home at the end	of the day.				
distances from	n your home or fron	day travel out of the area on a your work site and claim mu	st be supported with	event/meeti	ing documentatio	n.		
		se claims shall be fully item xpense or bridge toll require i	-	-		oint, destination	name and location,	
Date	Miles	Starting Point	Destination	1	Specific	Purpose	Bridge/Parking*	
Total:	at	cents per mile =				Total Other	:	
Funding:	District:		Lottery			Mileage:		
	Other:		Special Ed		Total Claim Reimbursement:			
Certification	<u>:</u>						* Receipts Required	
		a correct and true statement of erty loss and damage and per	-				ties. I further certify	
Signatures /	Authorizations:							
Employee / Claimant		De	Date District A		Administration		Date	
Site	e/Department Administratio	on Dat	Date Business		Administration		Date	
For District Of	-		_			D : 1 +		
		Account Code			Budget	Paid Amount	Date Paid	