P.O. #_____

COVINGTON INDEPENDENT PUBLIC SCHOOLS

REQUEST FOR REIMBURSEMENT

(Overnight Stay Only)

This is to request reimbursement of expenses incurred while attending_____

_____

_____

Beginning on_____and ending on_____.

Expenses for which reimbursement is requested;

Mileage_____ (CITY, STATE) (No. of miles) @ 58.5 cents/mile _____ *Use mileage chart whenever possible*	$
Other Transportation	$
Meals are reimbursed only when overnight stay is required at the rate of $ 46.00 per day. Number of overnight stays	$
Room (No. of nights)@	$
Registration Fees	$
Miscellaneous expenses (other tips, etc, Please List)	
Total Estimated Expenses	$

_____
PRINT STAFF MEMBER NAME

_____
HOME ADDRESS

_____
CONTACT PHONE NUMBER

_____ _____
SIGNATURE OF STAFF MEMBER DATE

_____ _____
Signature of Principal/Supervisor DATE

* Send to Accounts Payable @ Central Office

PRINT FORM