

TRACY UNIFIED SCHOOL DISTRICT TRAVEL AND EXPENSE CLAIM

Month of: _____, 2024

Name: _____ Employee# _____ Site: _____
 Address: _____ City _____ Ca Zip _____
 Account Number: _____

Note: Submit to the Finance office. Please attach all receipts and other supporting papers. Names of Organizations should be written in full; do not use initials. **Must be turned in within 30 days.**

Date	Miles	Destination & Purpose	Date	Miles	Destination & Purpose
1			17		
2			18		
3			19		
4			20		
5			21		
6			22		
7			23		
8			24		
9			25		
10			26		
11			27		
12			28		
13			29		
14			30		
15			31		
16					

MISCELLANEOUS EXPENSES: Do not use this form for conf/workshop reimbursements

Date	Description	Amount	Date	Description	Amount
		\$			\$
		\$			\$
		\$			\$

Signature of Claimant Date

Approved Supervisor Date
Rev 1/3/2024

Total Misc. Expenses:	\$
Miles @ \$.67	\$
TOTAL CLAIMED:	\$