SAN BENITO COUNTY OFFICE OF EDUCATION
MILEAGE AND DAY TRAVEL REIMBURSEMENT FORM

Note: Submit to Accounts Payable within 30 days of the end of the month.

Name _____ **PO #** _____ **Month/Year of Travel** _____

Home Address _____ CA ☐ **Check here if this is a NEW address**

Street **City** **State** **Zip**

Primary Site _____ **Claimant Telephone Number** _____

Date	Miles	Origin and Destination - By City or Actual Places Visited	Purpose for Travel	Misc. Expenses (eg., toll, parking, lunch, etc.)	Amount

Total Miles - **This Page**

Total Miles _____ **Second Page (if applicable)**

Total Misc Expenses -

Charges to each line of PO

Fund - Resource - Yr - Object - Sub - Goal - Function - Site	
Total (Must equal Total Reimbursement)	**$ -**

Total Miles - **Current Rate per Mile** @ **0.67** -

Total Reimbursement $ -

1) If claiming meals in misc expense, you must provide a copy of an agenda or conference flyer.
2) **Itemized receipts MUST be included for meals (breakfast=$20, lunch=$25, dinner=$35), parking under $5 or toll.**
3) I hereby certify that I possess a valid California driver's license, and I have insurance coverage **(copy attached)** as prescribed by Vehicle Code Division 7, Chapter 3, Article 2, Section 16451.
4) The above is true and correct to the best of my knowledge and belief.

Insurance Carrier _____

Attach copy of insurance verification

Claimant Signature **Date**

Approved by **Date**