

Mercer Island School District

Expense Claim Form

THIS FORM MUST BE SUBMITTED WITHIN TWO WEEKS OF THE TRANSACTION DATE. PLEASE DO NOT FILL IN THE SHADED AREA; BUSINESS OFFICE STAFF WILL CALCULATE TOTAL REIMBURSEMENT. IF MORE SPACE IS NEEDED, PLEASE FILL OUT AN ADDITIONAL FORM.



Name: _____ Address: _____

Date of Expense	Vendor	Itemized Expense (Description/Purpose)	SUBTOTAL
		TOTAL	

TOTAL REIMBURSEMENT (calculated by the Business Office)

\$ 0.00

Purchase Order (PO) Number or Account Code(s): _____

"I hereby certify under penalty or perjury that this is a true and correct claim for necessary expenses incurred by me and that no payment has been received by me on account thereof."

PLEASE ATTACH ORIGINAL RECEIPTS FOR ALL CLAIMS; COPIES ARE NOT ACCEPTED. APPROVAL BY PRINCIPAL OR SUPERVISOR IS REQUIRED. FAILURE TO COMPLY WITH EITHER WILL RESULT IN NO PAYMENT.

Employee Signature _____ Date _____

Approval by Principal or Supervisor _____ Date _____ ASB APPROVAL: _____