Karns City Area School District
Employee Mileage Reimbursement Form

Name:		**Building:**		**Begin Date:**	
Position:		**Phone:**		**End Date:**	

Mileage rate is for calendar year 2026

Date	Starting Location	Ending Location	Reason	Miles

Amount	Account						
	Fund	**Func**	**Obj**	**Lev**	**Bldg**	**Sub**	**Spec**
$0.00			**580**				

Total Miles	0.00
X Rate Per Mile (2025)	$0.725
Total Reimbursement	$0.00

Employee Signature: _____ **Date:** _____

Supervisor's Signature: _____ **Date:** _____

Use this form if you have mileage to be reimbursed. Return to the Business Office on a MONTHLY basis, by the 5th of the following month.

Edition 1/1/2026