TRAVEL REIMBURSEMENT REQUEST FORM
FISCAL YEAR JULY 1, 2021 TO JUNE 30, 2022

Staff Name: ______________________ **Program:** ______________________

The employee submits the following dates for supplemental reimbursement for travel related to his/her assigned employment at Davis Behavioral Health.

REIMBURSEMENT FOR MILEAGE

DATE	ROUTE	PURPOSE OF TRIP	MILES
		Total Miles Traveled	
NO ENTRY - CALCULATED FIELDS		Current mileage rate	
		TOTAL MILEAGE REIMBURSEMENT	

REIMBURSEMENT FOR OTHER EXPENSES (describe)

Total Other Expenses	

GRAND TOTAL OF REIMBURSEMENTS ______

I certify that the dates furnished above are true and that I have not been previously reimbursed nor claimed reimbursement for the stated expenses.

Signature of Traveler ______ Staff Code No. ______ Date ______

Supervisor's Approval ______ Date ______

TRAVEL WILL NOT BE PAID IF FORM IS NOT COMPLETE