

RESET

PRINT



RANCHO SANTIAGO
Community College District

MILEAGE REIMBURSEMENT CLAIM FORM

Employee Name: _____ Employee ID: _____ Phone #: _____

Location: _____ Department: _____ Position: _____

Claim Month: _____ Year: _____ Account #: _____

Date	Total Miles Driven	Check One		From: Name of Origin Street Address, City	To: Name of Destination Street Address, City	Purpose of Trip
		O/W	R/T			

Total Miles: _____ X \$ 0.56 / Mile = _____

I have liability insurance on my automobile and agree to maintain insurance coverage as long as I use my automobile for school business. I hereby certify that the above mileage represents a true and accurate statement of actual and necessary expense and that I have not been reimbursed for the above total.

Claimant Signature

Administrator Signature

Audited by: _____
Accounting Department Signature