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: 0.0 X $ 0.700/ Mile = $ 0.00

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

Mileage Rate of $0.70/mile as of 01/01/2025

Updated 12/30/24