Sutter Union High School District

REIMBURSEMENT REQUEST FORM

Full Name _____ Contact Number _____ Date _____

Program/Event/Sport/Etc _____

MILEAGE REIMBURSEMENT				
Date	From	To	Purpose	Total Miles
			Total Mileage:	0.00
			Rate Per Miles:	0.670
			Total Mileage Reimbursement:	$ **0.00**

EXPENSE REIMBURSEMENT			
Date	Vendor	Description	Amount
		Total Receipts to be Reimbursed:	$ **0.00**

Total Mileage + Expenses Reimbursement Requested:	**$**	**0.00**

Please attach original receipts, obtain Authorized Signature, and forward to Accounts Payable for processing.

By signature below, Requestor certifies that the above is a true statement of the expenses incurred in accordance with current state and local laws and regulations.

Requestor's Signature _____ Date _____ Authorized Signature _____ Date _____

OFFICE USE ONLY										
ACCOUNT CODE										
FD	RS	Y	OBJ	SO	GL	FN	SCH	BRS	DD1	DD2