

# EXPENSE CLAIM FORM

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**Employee Name:** \_\_\_\_\_  
 \_\_\_\_\_

**Work Location:** \_\_\_\_\_  
**Month/Year:** \_\_\_\_\_

**MILEAGE** (attach additional sheets if necessary)

| DATE | FROM | TO | ROUND TRIP<br>MILES | PURPOSE           |
|------|------|----|---------------------|-------------------|
|      |      |    |                     |                   |
|      |      |    |                     |                   |
|      |      |    |                     |                   |
|      |      |    |                     |                   |
|      |      |    |                     |                   |
|      |      |    |                     |                   |
|      |      |    |                     |                   |
|      |      |    |                     |                   |
|      |      |    |                     | x .58 per mile \$ |

**Per Diem Meal Reimbursement** -list each day in travel status. If traveling a day before or after the conference meals are paid at 75%.

| Date | BRKFST<br>\$18 Max/pp | LUNCH<br>\$19 Max/pp | DINNER<br>\$34 Max/pp | Travel Day<br>75% | Total |
|------|-----------------------|----------------------|-----------------------|-------------------|-------|
|      |                       |                      |                       |                   |       |
|      |                       |                      |                       |                   |       |
|      |                       |                      |                       |                   |       |
|      |                       |                      |                       |                   |       |
|      |                       |                      |                       |                   |       |
|      |                       |                      |                       |                   |       |

Note: For non-overnight trips lasting longer than 12 hours 75% of per diem will be paid.

\*Per Diem rates are based on the destination. Business Services will adjust accordingly.

TOTAL MEALS \$ \_\_\_\_\_

**OTHER EXPENSES** (attach receipts)

| DATE | VENDOR | PURPOSE/DESCRIPTION OF ITEMS | AMOUNT |
|------|--------|------------------------------|--------|
|      |        |                              |        |
|      |        |                              |        |
|      |        |                              |        |
|      |        |                              |        |
|      |        |                              |        |
|      |        |                              |        |

TOTAL OTHER EXPENSES \$ \_\_\_\_\_

**TOTAL REIMBURSEMENT REQUESTED** \$ \_\_\_\_\_

|   |  |  |   |
|---|--|--|---|
| <b>APPROVAL</b><br><br>Immediate Supervisor Signature _____ Date _____<br><br>Budget Authority Signature _____ Date _____   |  | <b>BUDGET CODE(S)</b><br>_____<br>_____<br>_____ | <b>AMOUNT OR PERCENT</b><br>_____<br>_____<br>_____ |
| <b>CERTIFICATION</b><br><br>I hereby certify under penalty of perjury, that this is a true and correct claim for necessary expenses incurred by me and that no payment has been received on account thereof.<br><br>Claimant's Signature _____ Date _____ |  |  |   |