MR __________

WASHOE COUNTY SCHOOL DISTRICT
Mileage reimbursement form

For the Period: ______________________ Page 1 of ______

MILEAGE REIMBURSEMENT FORM SHOULD BE SUBMITTED MONTHLY WITHIN 10 DAYS OF MONTH END. NOTE: THE BUSINESS OFFICE WILL ACCUMULATE MILEAGE REQUESTS UNTIL THE REIMBURSEMENT DUE EXCEEDS $10.00. REFER TO THE RULES ON PAGE 5 OF THIS FORM.

Please Print

Claimant Name: ______________________ Employee ID # E000 ______

Vendor # ______

Mailing Address (Checks will not be mailed to a school district address; address must match payroll records)

____

By signing below, claimant validates that they are operating their vehicle in accordance with Administrative Regulation 3545.2 which requires you to have a valid driver's license and liability insurance coverage and that, to the best of your knowledge, this request is true and correct.

Claimant Signature ______________________ Phone # __________ Date ______

Department / Principal Approval ______________________ Phone # __________ Date ______

Grant Program Approval (If required) ______________________ Phone # __________ Date ______

Budget Account to Charge Enter account code here Reimbursement Amount $ ______

Budget Account to Charge Enter account code here Reimbursement Amount $ ______

(For split funding reimbursement)

DATE	PURPOSE OF TRAVEL	FROM	ODOMETER READING	TO	ODOMETER READING	TOTAL MILES
District Mileage Chart will be used for travel between District locations. Actual odometer readings are required for travel not involving District locations.						
			Page 4 only		Page 4 only	

Use continuation sheet if needed

PAGE TOTAL MILES 0.0

Grand Total Miles 0.0