Santa Cruz County Office of Education
Mileage Reimbursement Claim Form

Name: **Dates Covered:**

ACCOUNT CODE:

Date	From	To	Purpose	Miles
			TOTAL:	

Approved by:_____ **I certify that this claim is true and correct.**

_____ _____

Program Manager **Date** **Employee's Signature** **Date**

Business Department Use Only

Total miles _____ at ___ cents per mile **= $**_____

Approved: _____ _____

Chief Business Official Date

Please make a photocopy for your records **prior** to turning in the **original** to Accounts Payable