SANTA BARBARA COMMUNITY COLLEGE DISTRICT

MILEAGE REIMBURSEMENT CLAIM

Submit monthly to the Accounting Office.
Must be signed by claimant and the supervisor.

Name _____ Period _____

Budget Account Number _____

DATE	FROM	TO	*OWT	*RT	MILEAGE
				TOTAL MILEAGE	

TOTAL MILEAGE   X   CENTS PER MILE = AMOUNT CLAIMED $

I certify that the foregoing is a true and correct statement of the use of my personal automobile for the necessary travel performed by me in carrying out my assigned duties as an employee of the Santa Barbara Community College District. The mileage reimbursement is at the rate set by the Board of Trustees.

_____
CLAIMANT'S SIGNATURE

*OWT - One Way Trip
 RT - Round Trip

_____
SUPERVISOR'S APPROVAL

FOR ACCOUNTING OFFICE USE ONLY

AUDITED :   PAID: DATE: _____
    DATE: _____   INITIALS: _____
    INITIALS: _____   WARRANT #: _____