LOCAL MILEAGE REIMBURSEMENT REQUEST

Name _____ **Month-Year** _____

Use the District Mileage Chart, whenever possible.

Date	From	To	Purpose	Mileage

For multiple pages: signatures are only needed on the last page.

I certify that the above is a true statement of the mileage incurred in accordance with CCSD policies and that I my reimbursement will be paid by direct deposit.

Total	
IRS Rate (Effective 01/01/2020)	$ 0.5750
Reimbursement	$

Employee Signature _____ Date _____

Budget Code _____

Supervisor's Signature _____ Date _____

Business Office Authorization _____ Date _____