Monthly Travel Expense Claim

Form C-2
Revised 1/1/21
ISD #318

Vendor No. _____

Pay To:
Name &
Address

Expense Code		Amount
Coded By:		Total: 0.00

Date Mo/Day/Year	From	To	Purpose	Miles	Other Exp.

I hereby declare under penalties of law that this claim is just and correct and that no part of it has been paid prior.

Signature of Employee _____ Date _____

Total Miles	0.00	
Rate per Mile		0.56
Total Mileage Expense		0.00
Total Other Expenses		0.00
Total Reimbursement Claimed		0.00

Signature of Principal/Athletic Director/Other _____ Date _____ Signature of District Administrator _____ Date _____