

Monthly Travel Expense Claim

Form C-2
Revised 1/1/22
ISD #318

Vendor No. _____

Pay To:
Name &
Address

Expense Code			Amount
Coded By:		Total:	

[illegible]

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

Rate per Mile

Total Mileage Expense	
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Total Other Expenses

Total Reimbursement Claimed	
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Signature of Principal/Athletic Director/Other

Date _____

Signature of District Administrator

Date _____