



2018-19 MILEAGE CLAIM FORM

Name:	
Address:	

- The rate of reimbursement is .545 cents per mile
 - Attach map/directions for all claims
 - Must remove your normal commute miles

DATE	DESTINATION	PURPOSE	MILEAGE

This claim form should be submitted to the Principal/Supervisor for approval. Once approved, form should be forwarded to the District Office. (The Superintendent must approve mileage claim for conferences.)

Total Mileage: _____ x \$.545 = _____

Claimant Signature: _____

Position: _____

Supervisor/Principal Approval Signature: _____

Superintendent/Business Administrator Signature: _____