

**Expense Report/ Reimbursement Form
2016-2017**

Name: Dr. Pamela Magee Date: 8/22/2017 P.O. # _____

<u>Date</u>	<u>Vendor</u>	<u>Description</u>	<u>Office Supplies</u>	<u>Classroom Materials</u>	<u>Conferences</u>	<u>Comm/Postage</u>	<u>Other*</u>	<u>Business Miles</u>	<u>Rate Per Mile</u>	<u>Total Mileage</u>
			4350	4310	5220	5920				5210
9/27/2017	Dr. Magee	LAUSD Charter Operated Programs - Option 3 Executive Council Meeting (round-trip from PCHS) John Tracy Clinic, 806 W. Adams Blvd., LA, CA 90007 (round trip from PCHS)						37.60	0.535	20.12
10/4/2017	Dr. Magee	CCSA Los Angeles - Fraud Workshop, Los Angeles (round trip from PCHS)						42.80	0.535	22.90
10/11/2017	Dr. Magee	LAUSD Regional Meeting, 474 Hartford Ave, Los Angeles (round trip from Santa Monica)						31.00	0.535	16.59
10/11/2017	Dr. Magee	Parking				\$12.00			0.535	\$12.00
									0.535	-
									0.535	-
									0.535	-
									0.535	-
									0.535	-
									0.535	-
									0.535	-
Total							12.00	111.40	0.535	71.60

Grand Total	\$	83.60
Charged Amount	\$	83.60
Net Due Employee	\$	71.60

Employee Signature: _____ Date: _____

Approved By: _____

Department/Program Name & #: _____

*- Provide full description on amounts in this column to allow for proper identification. Please submit original receipts for reimbursement. Reimbursement forms must be submitted within 30 days of purchase.