Expense Report/ Reimbursement Form
2016-2017

Name: Dr. Pamela Magee Date: 12/122017 P.O. # _____

Date	Vendor	Description	Office Supplies 4350	Classroom Materials 4310	Conferences 5220	Comm/ Postage 5920	Other*	Business Miles	Rate Per Mile	Total Mileage 5210
10/23 - 10/24	Dr. Magee	CCSA Conference San Francisco (round trip from Santa Monica to LAX) - CCSA sent a check to cover hotel/mileage. See attached. Reimburse Dr. Magee			145.40				0.535	-
									0.535	-
									0.535	-
									0.535	-
									0.535	-
									0.535	-
									0.535	-
									0.535	-
									0.535	-
									0.535	-
									0.535	-
									0.535	-
									0.535	-
Total			-	-	145.40	-	-	-	0.535	-

Grand Total	**$**	**145.40**
Charged Amount	**$**	**145.40**
Net Due Employee	**$**	**145.40**

Employee Signature: Pam Magee

Part 2

Approved By: _____ **Date:** _____

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.

Rev. 09/14