



Holmes County Consolidated School District of Transformation
 Lexington, Mississippi 39095
 Dr. Jennifer Wilson, Interim Superintendent

P.O. Number
Date:

Request for Travel Reimbursement

Name: _____ Employee I.D. Number: _____

Address (City/State only) _____

School/Division: _____ Job Responsibility: _____

Meeting/Activity: _____

Location: _____ Date(s) of Event: _____

[Date and Itemize Daily]

Date								
Day	SUN.	MON.	TUE.	WED.	THURS.	FRI.	SAT.	TOTALS
Hotel								\$
Meals								
Total								

Reimbursement for meals: Per Federal Register.
 RECEIPTS ARE REQUIRED FOR ALL EXPENSES
 EXCEPT MEALS.

Registration Fees.....

Airline Tickets (Tourist)...

Other.....

Automobile Mileage from _____ to _____ = _____ Total @ 0.585.....

Miscellaneous.....

TOTAL EXPENSES.....

Less Advancement.....

TOTAL REIMBURSEMENT

Attach receipts to substantiate all expenses	
Account Number	Total Amount
00	
01	
02	

\$
(-\$)
\$

In making this request for reimbursement, I hereby certify that the above expenses were actually incurred by me in the performance of my duties as an employee of the Holmes County Consolidated School District.

Signature of Employee: _____ Date: _____

APPROVED BY:
 Principal: _____ Date: _____

Director/
 Department Head: _____ Date: _____

District Level: _____ Date: _____