Blaine School District

Mileage Reimbursement Request

Employee Name: _____ Month: _____

Date	From	To	Total Miles *	Account Code	Purpose of trip	Amount @ 55.5 cents/mile
					Total Reimbursement Requested	

I certify under penalty of perjury that this is a true and correct claim for necessary expenses incurred by me and that no payment has been received by me on account thereof.

Employee Signature _____ Date: ____

Administrator Signature _____

*miles are calculated as the lesser of to/from home or the District Office.