CROSBY INDEPENDENT SCHOOL DISTRICT

TRAVEL EXPENSE REPORT

Vendor Name:______
PO No.___________________
Processed by:_______

Please note: The original form must be in BLUE INK.
Reimbursements will be processed from the original form only.

Name:____Budget Code:________________________________

Address:____Campus/Department:____________________

DATE	PURPOSE	FROM	To	MILES TRAVELED
			Reimbursement Rate	**X** $ 0.575
			Reimbursement Amount	

Travel reimbursement claims should be submitted to the Business Office within 30 days of completion of travel.

______________________________ ______________
Traveler's Signature Date

______________________________ ______________
Principal/Supervisor's Signature Date

______________________________ ______________
Chief Financial Officer's Signature Date