EXPENSE CLAIM FORM

NAME: **LICENSE PLATE:**

ADDRESS:

CITY: **STATE:** **ZIP CODE:**

BOARD/COMMISSION: **PHONE:**

California Association of Local Behavioral Health Boards and Commissions

DESTINATION:_____ **PURPOSE:**_____ **MONTH/YEAR:**_____

	Date:								**Receipts Y / N**
	Time:								
	Location To:								
	Location Fr:								
	TRANSPORTATION COSTS	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
(68321)	Airplane Fare								
(68326)	Railroad Fare								
(68327)	Ground Transportation (Taxi, Shuttle, etc.)								
(68323)	Private Auto Mileage (**Enter Miles)								
(68388)	Rental Vehicle								
(68328)	Other (Tolls, Parking, etc.)								
	TRAVEL RELATED EXPENSES								
(68317)	Breakfast -- $7								
(68317)	Lunch -- $11								
(68317)	Dinner -- $23								
(68329)	Incidentals $5 with receipts								
(68315)	Hotel/Motel Room & Tax								
	EXPENSES - OTHER - *Please list.*								
	TOTAL EXPENSE								

Mileage Rate: **0.535**

*2017 IRS mileage business reimbursement rate.

*Accounting Classification:*_____

CLAIMANT CERTIFICATION

I hereby certify that the above is a true statement of the travel or business expenses incurred by me; I have not and will not receive reimbursements for them from other entities.

SIGNATURE:_____