BIG SANDY ISD MILEAGE REIMBURSEMENT FORM

NAME OF EMPLOYEE _____ MONTH _____

CAMPUS/DEPARTMENT _____

RECORD OF TRAVEL

DATE	Location(s) Visited & Purpose of Travel	Miles Traveled

Total Miles: -

Mileage Rate: $0.450

Mileage Reimbursement: _____

I certify that the above mileage expenses are true and correct and were incurred by me in the performance of my official duties in accordance with Big Sandy ISD policy.

_____ _____

Employee Signature Date Supervisor Signature Date

Budget Code: _____