MCRAITH CATHOLIC CENTER EXPENSE/TRAVEL REPORT

Name:/Office: _____ Date: _____ Reimbursement Total: _____

Office Expenses	Dept #	Explanation	Amount
1.			
2.			
3.			
4.			
5.			

Total: 0.00

Reason for Transportation _____ Dates Traveled: _____

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Totals
Transportation								
Airfare								0.00
Parking/Tolls								0.00
Taxi								0.00
Auto								0.00
Gas								0.00
Total	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Lodging								
Hotels								0.00
Meals								
Breakfast								0.00
Lunch								0.00
Dinner								0.00
Total	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Other								
List								0.00
List								0.00
List								0.00
Total	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Mileage								
Actual Miles								0.00
@.545 per mile	0.545	0.545	0.545	0.545	0.545	0.545	0.545	
Total	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

TOTAL: 0.00

Approved by:_____ Date:_____

Form Revised 1/18/18