

THIS BOX FOR AUDITOR'S USE ONLY

VOUCHER NUMBER

PAYMENT DATE

**COUNTY OF SANTA CRUZ
TRAVEL REIMBURSEMENT**

CLAIMANT _____

WORKSITE _____

DEPT _____

PHONE _____

Reviewed By _____

Rep
Group

Gen; Mid; Exec; DA/CS Atty; Etc.

VENDOR NUMBER / SUFFIX	1 CK	DOCUMENT AMOUNT **	LNS	T/C HASH
		\$ -		

DESCRIPTION - INDICATE MONTH
(& purpose) OF TRAVEL >>>>

T/C	AMOUNT	INDEX	SUBJECT	USER CODE	DOC REF
150			4162		
150			4164		
150	\$ -		4166		
150			4168		
150					
	\$ -				
199			4180		
	\$ -				
	\$ -				

SUBJECT TITLE:

- LODGING-INCLUDING TAXES
- MEALS-and overnight incidental
- MILEAGE (From Reverse Side)
- OTHER (Explain on Reverse Side)
- DESCRIBE _____

Attach Receipts If Amount
Exceeds Per Diem

TOTAL THIS CLAIM (A)

TOTAL ADVANCE (B) See Below*

TOTAL OF A + B (Transfer this amount to AMOUNT line)**

TOTAL REIMBURSEMENT (A - B)

*Accounting for Travel Advance - The amount in line (B) must be less than or equal to line (A). Any amount greater than (A) must be refunded to the County by personal check or cash. This amount must accompany the travel claim form.

	DATES>>>					
County of Travel						
City of Travel						
Time of Departure						
Time of Return						
Meals-Breakfast						
Meals-Lunch						
Meals-Dinner						
\$5 Incidentals (overnight only)						
Per Diem: Overnight						
Per Diem: Taxable: No Overnight						
Lodging-Including Taxes						
Total Per Diem						

SIGNATURES - SEE CERTIFICATIONS ON REVERSE SIDE	
CLAIMANT	DATE
Supervisor	DATE
DEPARTMENT HEAD By:	DATE
CAMS Pre-Audit by A/C	DATE
Keyed by DPW/AC	DATE
Final audit by AC	DATE