Gateways Community Services

Mileage & Tolls Reimbursement *(Receipts for Tolls Required)

Date of Request: _____

Employee Name: _____

Address (only if new):_____

_____

_____

***Note $0.40 per mile reimbursement for transportation of clients.**

Date	*Mileage 0.36	*Mileage 0.40	Tolls	Description of Travel	Acct.#	Total @ .36 mile	Total @ .40 mile	Cost Center
						$ -	$ -	
						$ -		
						$ -		
						$ -		
						$ -		
						$ -	$ -	
						$ -	$ -	
						$ -	$ -	
						$ -	$ -	
						$ -	$ -	
						$ -	$ -	
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						$ -	$ -	
						$ -	$ -	
						$ -	$ -	
						$ -	$ -	
Total	0.00	0.00			7401	$ -	$ -	

Other Expenses ***(Receipts Required)**

Date	Expenses	Description	Acct. #	Total to pay		Cost Center
Total			**6534**	$ -		

Receipts required for tolls and other expenses.

Requested By:_____ Check Amount $ -

Approved By:_____

Director of Program

Requests received after 5:00 p.m. Monday will be processed the following Friday

Below for Finance Office Use Only

Account Number:_____

Date Posted_____