SOUTH CENTRAL WORKFORCE
TRAVEL APPLICATION FOR MILEAGE REIMBURSEMENT

Training Component:_____Total Contract Period:_____ to _____

Date:_____Name:_____SSN: _____

Address:_____

City/State/Zip:_____

TelephoneNo._____Program: _____

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Justification for Mileage Reimbursement:

_____
_____
_____
_____

Projection of Cost:

Dates of Training Mileage Paid: From _____ to _____ = _____Total Training Days

_____ Miles Per Day @ $_____ Per Mile = $_____ *Maximum Daily Amount Payable

Total Training Days____X Miles/Day_____X $_____Per Mile = $_____Total Contract Amount Payable

*Daily amount not to exceed maximum daily amount payable.

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"I understand mileage reimbursement will be paid only after the travel has occurred. Payment will be monitored by time sheet attendance and be paid according to specifications and limitations of above stated information."

_____ _____ _____ _____

Participant Signature Date Case Manager Signature Date

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Travel is_____Approved_____ Disapproved

If disapproved, reason: _____

_____

Supervisor Signature: _____ Date: _____