



St. Joseph Public Schools

Monthly Travel/Reimbursement Request- Effective January 1, 2024 (new mileage rate)

Date Submitted _____

Period Covered _____

Name _____

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Date	Description	Miles	Dollar	Meals	Other	Daily Total
Summary Totals						\$ -
Total Amount of Voucher						\$ -

*Other expenses are tolls, parking, etc.
No overnight lodging

Mileage rate- **0.67**
Effective January 1, 2024

Signature Date

I hereby certify that all items of expenses included in this statement were incurred in the discharge of authorized official business; that the amounts are correct and that they represent proper charges; against the SJPS.

Approval (Department Head or Supervisor) Date

Approval (Department Head or Supervisor) Date

Acct. No. _____
Acct. No. _____ \$ -
Acct. No. _____ \$ -

Gross Amount _____