



Travel Reimbursement Form

Name: _____ Date: _____

Program: _____ Supervisor: _____

Destination: _____ Purpose of Travel: _____

Date & Time Left: _____ Date & Time Returned: _____

Date	Nature of Expense	Amount Spent	GL/Fund/Loc/Proj Codes
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Sub Total

Less Advance

Balance Due Employee

Balance Due Employer

I certify this travel was completed by me and the above is true and correct. I have attached required receipts and all necessary back up including agendas for meetings and conferences. I have returned any advance overpayment to me by the employer.

Employee's Signature _____ Center Manager _____

Program Director _____ Executive Director _____

(Executive Director signature required if over \$1000 and/or out of state travel and if for Program Director)

Family Resource Center

125 North 17th Street
Saint Helens, OR 97051

Fiscal Office

124 North 18th Street
Saint Helens, OR 97051

Child & Family Programs

108 West B Street
Rainier, OR 97048