

**WESTERN ARIZONA COUNCIL OF GOVERNMENTS
POST-TRAVEL
EXPENSE STATEMENT**

PS _____

DEPARTMENT/ PROGRAM/ H.S CENTER

NAME: LAST	FIRST

ITINERARY (LIST ALL LEGS OF TRIP SEPARATELY)					
DATE	HOUR(AM-PM)	FROM	DATE	HOUR(AM-PM)	DESTINATION

SCHEDULE OF OTHER EXPENSES								
ENTER AMOUNT(ATTACH RECEIPTS)FOR REIMBURSEMENT OR INDICATE "DIRECT BILLING"(ATTACH RECEIPTS, IF ANY)								
DATE	GAS	PARKING	Checked in Baggage	MEETING EXPENSES	HOTEL	MEALS (IF NO QUARTERS REQUESTED)	(TAXI/SHUTTLE)	TOTAL

TOTAL OTHER EXPENSES TO BE REIMBURSED (ABOVE SCHEDULE)	1
EMPLOYEE'S MILEAGE: _____ MILES AT\$.45 PER MILE	2
PER DIEM ALLOWANCE: _____ QUARTERS AT \$9.00	3
SUBTOTAL (SUM OF LINES 1-3)	4
TOTAL ADVANCED AMOUNT	5
AMOUNT DUE (SUBTRACT LINE 5 FROM 4) (NEGATIVE-DUE AGENCY: POSITIVE-DUE TRAVELER)	6

CAR INFORMATION(POST-TRAVEL WILL NOT BE PAID WITHOUT VEHICLE LICENSE # AND MILEAGE) IF IT DOES NOT APPLY, WRITE N/A

LICENSE# _____ START MILEAGE _____ END MILEAGE _____

I CERTIFY THAT THIS STATEMENT,THE AMOUNT CLAIMED AND ATTACHMENTS ARE TRUE,CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE, AND THAT PAYMENT FOR THE AMOUNT CLAIMED HAS NOT BEEN RECEIVED.

REQUESTED BY

APPROVED BY

DATE

DATE