MARQUETTE COUNTY HEALTH DEPARTMENT
TRAVEL EXPENSE VOUCHER

NAME OF EMPLOYEE TITLE(POSITION)

HOME ADDRESS:

DATE SUBMITTED:

PERIOD COVERED:

FROM: TO:

Mileage rate: **$0.545**

		MILES BY PROGRAM								
DATE	DESCRIPTION	Admin	MHI	Preven.	STD	AMOUNT	HOTEL	MEALS	OTHER	TOTAL
						0.00				0.00
						0.00				0.00
						0.00				0.00
						0.00				0.00
						0.00				0.00
						0.00				0.00
						0.00				0.00
						0.00				0.00
						0.00				0.00
						0.00				0.00
						0.00				0.00
						0.00				0.00
						0.00				0.00
						0.00				0.00
						0.00				0.00
						0.00				0.00
						0.00				0.00
						0.00				0.00
						0.00				0.00
						0.00				0.00
						0.00				0.00
						0.00				0.00
						0.00				0.00
						0.00				0.00
						0.00				0.00
						0.00				0.00
						0.00				0.00
						0.00				0.00
						0.00				0.00
						0.00				0.00
						0.00				0.00
	Total Miles by Program	0	0	0	0					0.00
	TOTALS	0	0	0	0	0.00	0.00	0.00	0.00	0.00
									VOUCHER TOTAL	**0.00**

I HEREBY CERTIFY THAT ALL ITEMS OF EXPENSE 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 COUNTY.

NATURE OF OFFICIAL BUSINESS_____

_____ COC/HIV testing

_____

SIGNED_____

APPROVED_____

EXTENSIONS AND ADDITIONS CHECKED_____

MILEAGE CHECKED_____

EXPENDITURE CHECKED_____

VENDOR #_____

INVOICE #_____

Per Health Officer, Employees will either be paid for a meal or travel time but not both.