MARQUETTE COUNTY HEALTH DEPARTMENT
2020 TRAVEL EXPENSE VOUCHER

NAME OF EMPLOYEE ______________________

TITLE(POSITION) ______________________

HOME ADDRESS: ______________________

DATE SUBMITTED: ______________________

PERIOD COVERED:

FROM ______________________

To ______________________

Receipts are required for all reimbursements, including bridge receipts

All meal receipts must be itemized or explained, limited to 15% Ti Mileage rate: **$0.575**

Meals without reciepts are paid at the County rate

DATE	DESCRIPTION	MILES BY PROGRAM				AMOUNT	HOTEL	MEALS	OTHER	TOTAL
		0				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
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						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**

NATURE OF OFFICIAL BUSINESS______________________

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SIGNED ______________________

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.

APPROVED

Accounting Use Only	
Vender #	Invoice #
Acct.	Cost

Everyone:Forms/TravelExpense2020.xlsx