

**TRAVEL REIMBURSEMENT REQUEST**  
**Accounting Department**  
**Lincoln Public Schools**

Date: \_\_\_\_\_

Employee ID Number: \_\_\_\_\_ Name: \_\_\_\_\_ School: \_\_\_\_\_

Name of Activity: \_\_\_\_\_ Date(s) of Activity: \_\_\_\_\_

Location of Activity: \_\_\_\_\_

**Prior to Leave:** 1. Claimant completes Travel Reimbursement Request for any estimated amounts of expenses not paid directly by the district and sends the form to the administrator(s) who agreed to cover these expenses. 2. Administrator will indicate the maximum amount approved for expenses, sign the form and return the form to the claimant.

**Upon Return:** 1. After the activity is completed, the claimant will: a) List the expenses incurred. b) Attach receipts for all expenses, including travel, lodging, meals and registration. c) Sign the form. d) Send the form and all documentation to the administrator(s) whose account(s) will be charged. 2. The administrator will: a) Specify the amount approved. b) Provide the account number. c) Sign in the space provided below the account number. d) Send the form and documentation to Accounting for processing.

**Complete prior to requesting leave**

Travel Item	Estimated Expenses	Maximum Approved (Written Verification Required)
Travel: Auto _____ miles* Air _____ Other _____	\$ _____	_____ (Signature)
Lodging for _____ days	\$ _____	\$ _____ (Signature)
Meals for _____ days	\$ _____	\$ _____ (Signature)
Other Expenses: <input type="checkbox"/> Registration _____ _____	\$ _____	\$ _____ (Signature)
<b>Total</b>		

\*Mileage log must be attached.

Signature: \_\_\_\_\_

Audit for Payment: \_\_\_\_\_ (Auditor)

Date: \_\_\_\_\_

**Complete upon return**

Expenses Incurred	Amount Approved	Account Number (Signature Required)**
\$ _____	\$ _____	_____
\$ _____	\$ _____	_____
\$ _____	\$ _____	_____
\$ _____	\$ _____	_____
\$ _____	\$ _____	_____

\*\*If all expenses are covered by one administrator then one signature in total column is sufficient.

Original form, receipts, account numbers and appropriate signatures are required before reimbursement is processed.

I hereby certify that this claim is correct and is unpaid.

Date \_\_\_\_\_

Claimant Signature \_\_\_\_\_