CLAIM FOR REIMBURSEMENT FOR EXPENDITURES ON OFFICIAL BUSINESS

1. DEPARTMENT OR ESTABLISHMENT, BUREAU, DIVISION OR OFFICE

2. VOUCHER NUMBER

3. SCHEDULE NUMBER

Read the Privacy Act Statement on the back of this form.

5. PAID BY

4. CLAIMANT

a. NAME *(Last, first, middle initial)*

b. SOCIAL SECURITY NO.

c. MAILING ADDRESS *(Include ZIP Code)*

d. OFFICE TELEPHONE NUMBER

6. EXPENDITURES *(If fare claimed in col. (g) exceeds charge for one person, show in col. (h) the number of additional persons which accompanied the claimant.)*

Show appropriate code in col. (b):
A - Local travel
B - Telephone or telegraph, or
C - Other expenses *(itemized)*
D - Funeral Honors Detail
E - Specialty Care

(Explain expenditures in specific detail.)

DATE 20 ____ (a)	CODE (b)	(c) FROM	(d) TO	MILEAGE RATE / NO. OF MILES (e)	AMOUNT CLAIMED: MILEAGE (f)	FARE OR TOLL (g)	ADD PER-SONS (h)	TIPS AND MISCEL-LANEOUS (i)
	C							
If additional space is required continue on the back.			**SUBTOTALS CARRIED FORWARD FROM THE BACK**					
			TOTALS					

7. AMOUNT CLAIMED *(Total of cols. (f), (g) and (i).)* ▶ **$**

8. This claim is approved. Long distance telephone calls, if shown, are certified as necessary in the interest of the Government. *(Note: If long distance calls are included, the approving official must have been authorized in writing, by the head of the department or agency to so certify (31 U.S.C. 680a).)*

Sign Original Only

APPROVING OFFICIAL SIGN HERE ▶

DATE

9. This claim is certified correct and proper for payment.

Sign Original Only

APPROVING OFFICIAL SIGN HERE ▶

DATE

10. I certify that this claim is true and correct to the best of my knowledge and belief and that payment or credit has not been received by me.

Sign Original Only

CLAIMANT SIGN HERE ▶

DATE

11. CASH PAYMENT RECEIPT

a. PAYEE *(Signature)*

b. DATE RECEIVED

c. AMOUNT
$

12. PAYMENT MADE BY CHECK NO.

ACCOUNTING CLASSIFICATION