Community Connections, Inc.
Mileage Reimbursement Form

Name_____ **Month/Year :** _____

SUBMIT MILEAGE RECORDS WITH TIMESHEETS (No staples or paperclips)

Date	Customer Initials	Locations Driven	Beg Odometer or Trip Meter (0)	End Odometer or Trip Meter End	Total Miles
		Supervisor to Calculate	**Total Miles - This Page**		0.00

I certify that the above information is correct.

Employee Signature _____ **Date** _____

**********SUPERVISOR FILL OUT**********

GL	Program	Funding Source (If applicable)	Location	Miles (By program)	Amount (miles x 0.585)
7100	____ADM ____CMH ____ELP ____DD ____OARS	N/A	___KTN ___POW		
7100	____ADM ____CMH ____ELP ____DD ____OARS	N/A	___KTN ___POW		
7100	____ADM ____CMH ____ELP ____DD ____OARS	N/A	___KTN ___POW		
7100	____ADM ____CMH ____ELP ____DD ____OARS	N/A	___KTN ___POW		

Mileage rate effective 01/01/2022

Supervisor Signature _____ **Date** _____