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Last Name First Name

[illegible]

Employee Signature	Date
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***** SUPERVISOR TO COMPLETE *****					
GL	Program	Funding Source (If applicable)	Location	Miles (By program)	Amount (Miles x 0.67)
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		
Totals					

Mileage rate effective 01/01/2024

Supervisor Signature \_\_\_\_\_ Date \_\_\_\_\_