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Community Connections, Inc.

Mileage Reimbursement Form

2026

Last Name

First Name

- SUBMIT THIS FORM WITH YOUR TIMESHEET (NO STAPLES) -

[illegible]

I certify that the above information is correct:

Employee Signature

Date _____

***** SUPERVISOR TO COMPLETE *****					
GL	Program	Funding Source (If applicable)	Location	Miles (By program)	Amount (Miles x 0.725)
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 01/01/2026

Supervisor Signature

Date _____