

Mileage Reimbursement Form

***Area/Delegation Code:** **Request Date:**

***Check should be made payable and mailed to:**

Name:	
Street Address:	
PO Box, Suite Number:	
City/State/Zip Code:	

NOTE: A missing mailing address may delay the processing of this check.

Expense Breakdown Information:

*Travel Date	*Destination	*Activity/Event	*Beginning Odometer	*Ending Odometer	*Total Miles	*Total Dollars
__/__/__						
__/__/__						
__/__/__						
__/__/__						
__/__/__						
__/__/__						
__/__/__						
__/__/__						
__/__/__						
__/__/__						

***Total Mileage Reimbursement Amount:**

***Submitted by (must be signed):** _____

***Authorized by (must be signed):** _____

*Spaces marked with an asterisk must be completed before the check can be cut.
 *By signing this document, you acknowledge that, to the best of your knowledge, the information on this report is true and accurate.

Cutoff for check requests is Tuesday at noon for CORRECTLY completed Check Request forms. Checks are cut on Wednesday and are mailed no later than Friday. Original receipts must be attached! No receipt = no reimbursement. Special Olympics Minnesota will not accept expense Reimbursement requests with any receipts more than 60 days old!