

REIMBURSEMENT FORM

Pecatonica C.U.S.D. #321

Name _____ Date _____

Date(s) of mtg. _____ Location of mtg. _____

.....

REGISTRATION FEE _____ Previously paid by district (\$_____)
_____ Paid by employee (\$_____)
..... **subtotal \$** _____

ACCOMMODATIONS Hotel \$ _____
..... **subtotal \$** _____

MEALS	Breakfast	Lunch	Dinner
Date _____	_____	_____	_____
Date _____	_____	_____	_____
Date _____	_____	_____	_____

Meal receipts must be itemized. Reimbursement for alcoholic beverages is prohibited.
..... **subtotal \$** _____

TRAVEL _____ miles at \$.58 per mile _____
(Proof of insurance is required for mileage reimbursement)
Cabs/Tolls/Tips/Parking _____
Other _____
..... **subtotal \$** _____

..... **TOTAL REIMBURSEMENT DUE \$** _____

Professional leave for Certified Staff limited to 3 total days, \$800 total cost (including travel reimbursements) per year.

Principal's Recommendation _____
Approved _____ Not Approved _____ Date _____

Superintendent's Recommendation _____
Approved _____ Not Approved _____ Date _____

Receipts are required for reimbursement.