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 $.575 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.

Updated 01/2020