

Rockingham County Nursing Home
MILEAGE REIMBURSEMENT

Current Information – please complete for all transactions:

Name: _____ Dept: _____

I certify the miles listed above are accurate and were traveled in the performance of assigned duties.

Employee Signature: _____ **Date:** ____/____/____

Mileage Calculations:

Total Miles _____ @ \$ _____ per mile = \$ _____

Total Tolls _____ Total Travel Reimbursement \$ _____

Admin Use:

Approved _____

Amount _____

Bid _____ T # _____

CC _____ By _____

Date _____ Confirm _____

Acct No. 11700000 53903

Approvals:

Dept Mgr/Supvsr: _____ / ____/____

O/DD: _____ / ____/____