

**SNOQUALMIE VALLEY SCHOOL DISTRICT #410
IN-DISTRICT MILEAGE CLAIM FORM**

Employee Name: _____ **School Position:** _____ **Claim Date:** _____
(Name must match SVSD HR records)

Reimbursement must be submitted within sixty (60) days after the expense is incurred per IRS regulations. The Employee's reimbursement will be deposited into their bank account on the last business day of the month, if this request is received prior to the monthly cutoff date. Please consult the Business Office for cutoff dates: (425) 831-8011. Mileage to and from work will not be reimbursed.

DATE (MM/DD/YYYY)	SCHOOL LOCATION		REASON	MILES
	FROM	TO		
			TOTAL MILES	

TOTAL MILES: _____ @ \$0.58 per mile (eff. 1/1/19)
TOTAL REIMBURSEMENT: \$ _____

CERTIFICATION: I hereby certify under penalty of perjury: that this is a true and correct claim for necessary expenses incurred during the conduct of official school business. That no payment has been received by me on account thereof; that no rebate of any character, kind, or description has been made to me by any person or persons furnishing any of said transportation; that the expenses charged were actually and necessarily incurred and paid by me in lawful money.

SIGNATURE OF CLAIMANT: _____ DATE: _____

SUPERVISOR APPROVAL: _____ DATE: _____

ACCOUNT CODE: _____

BUSINESS OFFICE APPROVAL: _____ DATE: _____