PIMA HEALTH SYSTEM MILEAGE REPORT

(Present with Check Request Form)

NAME: _____

MONTH OF: _____ YEAR 20___ CAR/VEHICLE LICENSE NUMBER: _____

The mileage report must be accurate and easy to read in order to be paid as quickly as possible:

- Enter your name
- Enter the month & year the mileage applies to.
- Enter your car/vehicle license number.
- Enter the date of travel. Enter one 1-way trip per line. **(A)**

- Enter the address traveled from. **(B)**
- Enter the address traveled to. **(C)**
- Enter beginning odometer reading. **(D)**
- Enter the ending odometer reading. **(E)**
- Enter total miles (subtract beginning from ending odometer reading) **(F)**
- Sign form**. (G)**

A	B	C	D	E	F
DATE	**FROM ADDRESS**	**T0 ADDRESS**	**ODOMETER BEGINNING**	**READING ENDING**	**TOTAL MILES**
				Total this page	

I hereby certify that the above amounts are correct and were expended in discharge of duties to the benefit of the County.
My signature below indicates that I have a valid driver's license, current vehicular liability insurance and current registration.
(G)

Claimant _____
(ACW Signature)

Department Head_____
(Signature)

(To be completed by manager/supervisor.)

Miles _____
Deduction Miles _____
Total Miles (Round to nearest mile) _____
X 0.505
Mileage Reimbursement $ _____
Parking Expense, if applicable $ _____
TOTAL $ _____

(Continued on back)

``````CONTINUATION

A	B	C	D	E	F
DATE	**FROM ADDRESS**	**T0 ADDRESS**	**ODOMETER BEGINNING**	**READING ENDING**	**TOTAL MILES**
				Total this page.	