

# Milford Regional Physician Group

*The Benchmark for Quality Care*

## TRAVEL REIMBURSEMENT REQUEST

(TO BE SENT TO ACCOUNTS PAYABLE AT THE FINANCE OFFICE AFTER SUPERVISOR APPROVAL)

REIMBURSEMENT TO: \_\_\_\_\_

DATE SUBMITTED \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

COST CENTER \_\_\_\_\_

	1	2	3	4
DATE	DESTINATION/PURPOSE	MILEAGE (TOTAL LESS COMMUTING)	PARKING (RECEIPTS REQ'D)	TOLLS (RECEIPTS REQ'D)
<b>Total miles</b>				

MILEAGE - TOTAL MILES (COL. 2) X 54 CENTS \*\*

\_\_\_\_\_ (A)

NON-MILEAGE COSTS (COL. 3 AND 4)

\_\_\_\_\_ (B)

TOTAL

\_\_\_\_\_

\_\_\_\_\_  
EMPLOYEE DATE

\_\_\_\_\_  
SUPERVISOR APPROV DATE

\*\* RATE EFFECTIVE JANUARY 1, 2016