ADMINISTRATIVE, SUPERVISORY & CLINICIAN STAFF EXPENSE CLAIM

For the Period Ending: _____

Name: _____ **Program Number:** _____

Position:

MILEAGE

Date	From	To	Purpose of Trip	Kilometers
			TOTAL KILOMETERS:	0.45
			0.45 per KM	0
				$ 0.00

OTHER EXPENSES

Date	Particulars	Amount
	Total Other Expenses	$ 0.00
	Total Claim	$ 0.00

I certify that the above is a true and accurate statement of expenses incurred in the performance of the duties of my postion.

_____
Applicant

_____
Approval