

Professional Day Reimbursement Request

Maroa Forsyth C. U.S.D. #2

Name _____

Date of Request _____

_____ Administration Requested I Attend

_____ I Requested to Attend

Date of Conference	Name of Conference	Registration Fees Paid *	Miles Driven**	Total Reimbursement Requested

* Registration Fee not to exceed \$140.00 per day *(Receipt or cancelled check for registration fees required)*

** Mileage not to exceed 100 miles, paid at IRS rate

*** Only one mileage reimbursement claim paid per conference *(carpooling required)*

Please provide copies of certificates of completion or other evidence of attendance.

Please provide a 2-3 sentence summary of the conference highlights

Employee Signature _____

For Office Use Only	
Date Received	_____
Date Processed	_____
Check #	_____