Surrey Schools

LOCAL TRAVEL EXPENSE CLAIM
KILOMETREAGE REIMBURSEMENT

Name _____

Position _____

School / Dept. _____

Bus Telephone _____ Employee # _____

Vendor # EM		
MI		
MI	231031	$ 0.00
MI		
MA	231031	$ 0.00

YEAR : 20 23 **MONTH:** October

Budget Account #:

Enter applicable 16 digit numeric GL code without dashes.

Kilometres are to be claimed monthly, use a new form for each new month.

Claims in excess of 90 days from month end will not be paid.

Date of Month	Point of Origin and Point of Destination	Reason for Travel or Expenditure	KMS	Misc. Expenses

Claimant is responsible for accuracy of data, adding up claim and routing to Supervisor for approval. Attach original receipts where required. Supervisor is responsible to ensure validity of claim and seek Budget Officer approval. Budget Officer (if also claimant's supervisor) must affix account number.

Total Kilometerage and Misc. Expenses	0.00	$ 0.00
Rate per KM	$ 0.70	$ 0.00
Total Claim		$ 0.00

Certification: **I certify that all expenses incurred above are true and just in all respects; are related to Board business, that none have been claimed from other organizations; that they comply with Board Policy 4100.1- Internal Controls Expenditure Management Expenditure Reimbursements, and that I personally paid for them and that I actually incurred or paid the operating expenses of the motor vehicle for which reimbursement is claimed on a kilometre basis.**

Claimant's Signature _____ Date _____

Approval: **Your signature indicates approval as to the appropriateness and reasonableness of the expenses being claimed.**

Approver's Signature _____ Date _____

Budget Officer Approval _____ Date _____

Distribution: **Forward completed and approved form, including all original receipts,to Fiscal Management Services Courier # 473**

Form 6240.4 Rev.2024/06