ATTACHMENT 1

OCHSNER HEALTH SYSTEM
MILEAGE REIMBURSEMENT FORM

Employee's Name _____ Employee ID# _____

Home Address _____

Facility _____

Department Name / Cost Center Number _____

Normal Commute Miles - One Way (only deducted if starting/ending location is home address) _____ miles

Month/Period Covered _____

DATE OF TRIP	PARAMETERS OF MILEAGE		REASON MILEAGE INCURRED	MILES DRIVEN	AMOUNT DUE ($.585/MILE)
	STARTING LOCATION	ENDING LOCATION			
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
			TOLL RECEIPTS/PARKING FEES TOTAL AMOUNT(IF APPLICABLE) - **ATTACH ALL RECEIPTS TO AN 8 1/2 x 11 SHEET OF PAPER**		
			GRAND TOTAL (both columns)	0	$

By signing this request I acknowledge that I carry the minimum motor vehicle and liability insurance required by Louisiana State Law on the Vehicle used for the above trips.

Employee Signature _____ Date _____

Approval Signature _____ Date _____
One Level Up, Manager or Higher

NOTE: This form, along with any backup documentation, can be scanned as a .pdf document and e-mailed to APInvoices@ochsner.org.

Donna Guidroz, Director – Graduate Medical Education

This form is to be used only when expenses relate to reimbursement for the use of a private motor vehicle used between Ochsner Health System facilities on approved business related matters.

NOTE: Submit to Accounts Payable for reimbursement monthly.