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 | | | |
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| | | | 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 Program Director Signature Date

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.