

OCHSNER HEALTH SYSTEM MILEAGE REIMBURSEMENT FORM

Employee's Name			Employee ID#		
Address			1 3		
Facility					
Department	Name				
Department (Cost Center) Number			Acct# 84220		
Period Covered by this Voucher			ТО		
					_
DATE	PARAMETERS OF MILEAGE		REASON MILEAGE	MILES	AMOUNT DUE
OF TRIP	STARTING LOCATION	ENDING LOCATION	INCURRED	DRIVEN	(\$.51/MILE)
					+
				,	
				,	
					
					_
	TOLL RECEIPTS/PARK	ING LOT FEES TOTAL AMOU	NT(IF APPLICABLE)		
	- <u>ATTACH ALL R</u>	ECEIPTS TO AN 81/2 x 11 SH			
			TOTAL (both columns)		
	nis request I acknowledg			iability insu	ırance
required by I	Louisiana State Law on t	the Vehicle used for the	above trips.		
Employee Signature		Date	One Level Up		Date
			Approval Signature		
NOTE: This	form, along with any bad	ckup			
	on, can be scanned and	e-mailed to			
MileageReimburse@ochsner.org.			Approver Printed Name and Title		

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 when amount exceeds \$25.00 but not more than once per month.