MINERS' COLFAX MEDICAL CENTER

TRAVEL REQUEST FORM

PO:

Date:

Cost Center:

NCE Code:

Approval:

1. Name of Person Taking Trip:
2. Department and title/position:
3. Reason for travel:

## TRAVEL PLAN

MUST BE COMPLETED AND APPROVED PRIOR TO TRAVEL

1. Point of Departure:
2. Destination:
3. Number of Days Required:
4. Departure Date:
Departure Time:
5. Return Date:
Return Time:
6. Mode of Travel:

If Personal Vehicle, model:

License#:  Year:

Mileage:

 ACCOUNTS PAYABLE USE ONLY

Using State Vehicle:

Per Diem:

 ACCOUNTS PAYABLE USE ONLY

TRAVEL PLAN MUST BE APPROVED PRIOR TO TRIP

I request approval for the travel plan and certify that it is necessary for the performance of my Job duties.

Traveler’s

Signature:

 Date

Approval

Signature:

 Date

# **ACTUAL REPORT**

COMPLETED UPON RETURN; NOTE ALL CHANGES

Check to confirm:

Note any changes:

Check to confirm:

Per Diem Adjustments:

 ACCOUNTS PAYABLE USE ONLY

I certify that this travel report and related reimbursement is true and correct and that the travel was necessary for the performance of my Job duties.

Traveler’s

Signature:

 Date

Approval

Signature:

 Date