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	**ACTUAL REPORT** COMPLETED UPON RETURN; NOTE ALL CHANGES
4. Point of Departure: _____	
5. Destination: _____	
6. Number of Days Required: _____	
7. Departure Date: _____	
Departure Time: _____	
8. Return Date: _____	
Return Time: _____	
9. Mode of Travel: _____	
If Personal Vehicle, model: _____ License#: _____ Year: _____ Mileage: _____ ACCOUNTS PAYABLE USE ONLY	Check to confirm: _____ Note any changes: _____
Using State Vehicle: _____ Per Diem: _____ ACCOUNTS PAYABLE USE ONLY	Check to confirm: _____ Per Diem Adjustments: _____ 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	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