

**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

Using State Vehicle: _____
 Per Diem: _____
ACCOUNTS PAYABLE USE ONLY

Check to confirm: _____
 Note any changes: _____

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.

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

Traveler's
Signature: _____
Date

Approval
Signature: _____
Date

Approval
Signature: _____
Date

Second Approval
Signature: _____
Date

Second Approval
Signature: _____
Date