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.

Travel 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

This travel request is required for official MCMC business and is approved to exceed the annual aggregate reimbursement limit of $1500.

CEO Approval: _____
Date

Second Approval Signature: _____
Date