



NCJUSD

North County Joint Union School District

2024 Mileage Reimbursement Claim Form

Name: _____

Month(s) of: _____

Address: _____

DATES	DESTINATION	PURPOSE	MILES
		TOTAL MILES	
		x RATE OF \$0.67	\$ 0.67
		<i>TOTAL MILEAGE EXPENSE</i>	\$

Employee Signature

Date

Superintendent Signature

Date

FND	RESC	Y	OBJT	SO	GOAL	FUNC	CSTCTR	STE	MGR	Amount
		0	5210	00				000	0000	
		0	5210	00				000	0000	

Total for this claim: _____