SEMINOLE COMMUNITY COLLEGE

Business office use only: Employee Vendor#
_____

SECTION I Name: _____Employee ID # _____

Department _____Department ID#_____ Destination_____

Beginning Travel Date: _____ Time: _____am/pm Ending Travel Date: _____ Time: _____am/pm

Purpose of Travel _____

Estimated expense column must be completed. No reimbursement will be provided without proper approvals

SECTION II - Estimated Expenses and SPD Support

Faculty F/T___ P/T____ Staff F/T _____P/T____

Are you requesting SPD funding for this travel? Yes ____ No ____

If yes, how much are you requesting? $_____

Have you used SPD funding this fiscal year? Yes _____ No _____

SPD REP USE ONLY $ _____

SECTION III - Reimbursement Request (return to Business Office)

Attach an **SPD RETURN FROM TRAVEL REPORT**

If **SPD** funds were granted.

Departed From: _____ **Time** _____**Date** _____

Returned To: _____**Time** _____ **Date** _____

	Estimated Expenses	**Reimbursement Request**	**Business Office Adjustment**
_____ With Pay ___ Without Pay	- - - - - - - - - - - - - - - - -	- - - - - - - - - - - - - -	- - - - - - - - - - - - - -
_____ Mileage (Map ___ Odometer ___)	_____	_____	_____
_____ Direct Mileage + ____Vicinity Mileage	_____	_____	_____
_____ Airfare (Check Request_____)	_____	_____	_____
_____ Meal Allowance OR Per Diem (select one)	_____	_____	_____
_____ Lodging (Check Request_____)	_____	_____	_____
_____ Registration (Check Request_____)	_____	_____	_____
_____ College Vehicle _____Fuel/Oil	_____	_____	_____
_____ Car Rental/ Fuel ___ (ACTO yes____ no____)	_____	_____	_____
_____ Parking _____Tolls ____Ground Transportation	_____	_____	_____
_____ Telephone/Business Comm.	_____	_____	_____
_____Misc (specify)	_____	_____	_____
	Total$_____	**Total Amount Reimbursement**	**$**_____

Budget Center #___-_____-_____-_____ Acct._____ $_____
Fund Program Dept Class

Budget Center #___-_____-_____-_____ Acct._____
Fund Program Dept Class

Budget Center #___-_____-_____-_____ Acct._____ $_____
Fund Program Dept Class

Budget Center #___-_____-_____-_____ Acct_____
Fund Program Dept Class

_____ _____ _____ _____
First Budget Administrator **Date** **Supervisor** **Date**

_____ _____ _____ _____
Second Budget Administrator **Date** **SPD Rep** **Date**

SECTION IV Initials of Budget Administrator(s) if Reimbursement Request exceeds10% of the Estimated Expenses _____
First **Second**

CERTIFICATION OF TRAVELER:

I hereby certify that the above expenses were incurred by me as necessary travel expenses in the performance of my official duties; attendance at a conference or workshop was directly related to my official duties; any meals included in a conference or workshop registration fee have been deducted from this reimbursement claim; I have not received and will not receive compensation for any portion of the time absent or reimbursement for traveling expenses from any source other than Seminole Community College and that this claim is correct and conforms with policies related to traveling expenses. **If requested SPD Support a "Return From Travel Form" must be submitted within 30 business days.**

Traveler's Signature: _____ **Date:** _____

SECTION V Business Office Use Only:
Audited By: _____ **Date**:_____ **Total Reimbursement $**_____

Copy Distribution: (White)Business Office (Yellow)Traveler (Pink)Department (Gold)Business Office 30Rev12-03