



OREGON COAST COMMUNITY COLLEGE  
Expense Request for Payment

<b>DEPARTMENT:</b>		
<b>PERIOD COVERED:</b>	<b>From:</b>	<b>TO:</b>

Rate: 0.535

Date	Purpose/Explanation	Mileage		Meal Reimbursement			Lodging	Other Expenses	Account Number	Total
		Miles	Amount	Breakfast	Lunch	Dinner				
			0.00							0.00
			0.00							0.00
			0.00							0.00
			0.00							0.00
			0.00							0.00
			0.00							0.00
			0.00							0.00
			0.00							0.00
			0.00							0.00
			0.00							0.00
			0.00							0.00
			0.00							0.00
			0.00							0.00
<b>SUBTOTALS:</b>		0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

EMPLOYEE/VENDOR NAME AND ADDRESS (Please print)		EXPENSES BY ACCOUNT					
				TOTAL:		SUBTOTAL:	
				TOTAL:		LESS ADVANCE:	
				TOTAL:		TOTAL DUE: -	
ZIP:				TOTAL:	-		
					-		

I certify that all reimbursements claimed reflect the actual amount spent and that no part has been previously claimed or will be claimed from any other

Supervisor's Signature:	Date:
Business Office Signature:	Date:
President's Signature:	Date:

Attach receipts and additional pages, if and as necessary.