DAKOTA 911
POLICE • FIRE • EMS

REIMBURSEMENT REQUEST

EMPLOYEE INFORMATION

NAME: _____

ADDRESS: _____

_____

☐ **CLAIM** DATE _____

☐ **MILEAGE** FROM: _____ TO: _____

☐ **TRAVEL** FROM: _____ TO: _____

CLAIM EXPENSES			
DATE	**DESCRIPTION**	**CODE**	**COST**
		Select One	
		Select One	
		Select One	

MILEAGE EXPENSES					
DATE	**LOCATION**	**MILES**	**DATE**	**LOCATION**	**MILES**

*Travel on scheduled work day is lesser of work to event or home to event.
*Travel on day off is home to event.

2024 Rate/Mile: .67/MILE

TOTAL MILES 0

EVENT EXPENSES

REASON: Select One

EVENT & LOCATION: _____

PREPAID (entered by Ops Director upon receipt)					
REGISTRATION	**MATERIALS**	**AIRFARE**	**BAGGAGE**	**LODGING**	**TOTAL**
					$ 0.00

TRAVEL							
ITEM							
BREAKFAST							
LUNCH							
DINNER							
TRANSPORTATION							
BAGGAGE							
OTHER (Explain)							

ORIGINAL RECEIPTS MUST BE ATTACHED TO THIS CLAIM FORM.

TRAVEL EXPENSES	$ 0.00
TOTAL TRAVEL COST	$ 0.00
NON-DCC EXPENSES (ENTER AS -)	
TOTAL DAKOTA 911 TRAVEL COST	$ 0.00

NOTES

REIMBURSEMENTS

CLAIMS (GL: see detail)	**$ 0.00**
MILEAGE (GL: 8950.6234)	**$ 0.00**
TRAVEL (GL: 8950.6311)	**$ 0.00**

_____ EMPLOYEE SIGNATURE

_____ DIRECTOR SIGNATURE

PRINT **RESET**