

UNITED CEREBRAL PALSY of Central Pennsylvania, PaRC SUPPORT PROJECT
55 Utley Drive, Camp Hill, PA 17011, Phone (717) 975-2004, Fax (888) 524-9282
PaRC TRAVEL REIMBURSEMENT WORKSHEET

1. MEMBER NAME: _____

2. ADDRESS: (where check is to be delivered)

3. MEETING DATE: _____

4. MEETING LOCATION: _____

5. DATE AND TIME YOU LEFT HOME TO ATTEND THIS MEETING:

DATE: _____ TIME: _____

6. DATE AND TIME YOU ARRIVED HOME FOLLOWING THIS MEETING:

DATE: _____ TIME: _____

Transportation Expenses

1. IF YOU TRAVELED BY AUTO, HOW MANY MILES IS IT FROM YOUR HOME TO THE STATION/AIRPORT OR TO THIS MEETING SITE (one-way)? _____

2. IF YOU TRAVELED BY AIR, RAIL, TAXI, ETC., WHAT WAS THE AMOUNT OF YOUR ROUND TRIP TICKET? (Necessary to include receipts or copies of vouchers)

RAIL: _____ AIR: _____ TAXI: _____

BUS: _____ TOLLS: _____ PARKING: _____

Attendant/Driver/Reader Information (Each Attendant/Driver/Reader must fill out their own timesheet with signature.)

1. ATTENDANT NAME: _____
of hours: _____ (\$10.20/hour for 14 hours in a 24-hour period.)

2. DRIVER NAME: _____
of hours: _____ (\$10.20/hour)

CONTINUED ON BACK ...

3. READER NAME: _____
of hours: _____ (\$10.20/hour)

Meal Expenses -- (use same format on a separate piece of paper for additional days) **Receipts Required – no per diems.**

DATE: _____
BREAKFAST: _____
LUNCH: _____
DINNER: _____
TOTAL: _____

DATE: _____
BREAKFAST: _____
LUNCH: _____
DINNER: _____
TOTAL: _____

DATE: _____
BREAKFAST: _____
LUNCH: _____
DINNER: _____
TOTAL: _____

DATE: _____
BREAKFAST: _____
LUNCH: _____
DINNER: _____
TOTAL: _____

**** EACH PERSON CLAIMING EXPENSES SHOULD COMPLETE THIS FORM****

FOR STAFF USE ONLY:

Total Miles: _____ x \$.545 = _____
Total Meals: _____
Total Attendant: _____
Total Driver: _____
Total Reader: _____
Total Transportation Expenses (Tolls, etc.): _____
Any Deductions: _____

GRAND TOTAL DUE MEMBER: _____

Member Signature / Date

PaRC Support Staff Signature / Date