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: _____ ($10.35/hour for 14 hours in a 24-hour period.)

2. DRIVER NAME: _____
   # of hours: _____ ($10.35/hour)

3. READER NAME: _____
# of hours: _____ ($10.35/hour)

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

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

DATE:	_____	**DATE:**	_____
BREAKFAST:	_____	BREAKFAST:	_____
LUNCH:	_____	LUNCH:	_____
DINNER:	_____	DINNER:	_____
TOTAL:	_____	**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
Revised: 07/18