

Reach Out and Read Colorado Mileage Reimbursement Form

Date: _____
 Name: _____
 Clinic: _____
 Clinic Phone: _____
 Rec'd By: _____

Date	Number of Miles	From	To	Why
		(clinic location)	(destination)	(purpose)
			Denver	Statewide Conference
		Denver		Statewide Conference
Total	0			

Rate: @ .50 per mile x Total Miles = 0.00

Name

Signature

FOR ROR CO USE ONLY

Receipts attached?	Yes	No
Approval: _____	Date: _____	_____
Date Paid: _____	_____	_____
Check #: _____	Date: _____	_____

Directions:

PLEASE PRINT LEGIBLY.

Fill out date, your name, clinic name, and phone number.

Fill in estimated number of miles and where you traveled from.

Fill in estimated number of miles and where you are traveling back to.

Return this form to Melissa Elgersma or a Reach Out and Read Colorado Staff Member

You can also fax this form to: 303-300-3801 Attn: Melissa

YOU SHOULD RECEIVE YOUR REIMBURSEMENT CHECK BY JUNE 15TH. IF YOU DO NOT, CONTACT ROR CO.