Travel Advance Payment Request Form (ACC-FO21)

School/Department: _____ Today's Date: _____

Employee Name: _____ Employee ID Number: _____

Job Title/Work Location: _____ Work Phone Number: _____

Home Address: _____
Street *City* *State* *Zip Code*

Travel To (Destination): _____ Date(s) of Travel: _____
Departure Date *Return Date*

Business Purpose of Travel: _____

# of District Travel Days: _____ # of Personal Travel Days: _____ Total # of Travel Days: _____

Estimated Out-of-Pocket Travel Expenses

Estimate your out-of-pocket travel expenses for this trip that will not be prepaid directly by SCUSD.
You must complete the Travel Reimbursement Form (ACC-F013) within 5 days of completing this trip.

Air Fare: *Departure Flight #/Time:* _____ *Return Flight #/Time:* _____ $ _____

Lodging: *Date Checking In:* _____ *Date Checking Out:* _____ $ _____

Rental Car: *Pick up date:* _____ *Return date:* _____ $ _____

Meals & Incidentals:

Find your per diem allowance rate at www.gsa.gov/perdiem.

Partial day of departure (First Day) 75% x portion of per diem amount $ _____ = $ _____

Partial day of return (Last Day) 75% x portion of per diem amount $ _____ = $ _____

Total full days of travel: _____ x daily per diem amount $ _____ = $ _____

Mileage: *(Incurred in your personal vehicle only)* $ _____

Registration Fee: *Description:* _____ $ _____

Local Transportation: *(Taxi, shuttle, subway, etc.)* $ _____

Other: *(Describe)* _____ $ _____

_____ $ _____

_____ $ _____

Total Estimated Cost for This Trip: $ $ 0.00

Special Instructions: _____

_____

In accordance with Education Code Section 42804, ineligible purchases made from per diem payments become my personal liability.

I understand I must return original itemized receipts and/or unused funds to the district with a completed Travel Reimbursement Form (ACC-F013) within 5 days of return. Should I fail to return funds and/or proper documentation such as itemized receipts or if I make ineligible purchases, I hereby authorize Sacramento City Unified School District to deduct the disallowed amount from my salary.

_____ _____ _____ _____

Employee's Signature *Date* *Supervisor's Signature* *Date*

Please send original to Accounting Services (BOX 802)