Independent School District No. 625
Saint Paul Public Schools
360 Colborne Street, Saint Paul, Minnesota 55102-3299

Mileage Reimbursement Request- Plan A

Page ___ of ___

Name & Home Address (Please Print Legibly):	Month/Year of Miles Driven
	Title:
	School/Department:
Employee Number:	

MM/DD/YY **Date**	**From**	**To**	**Purpose**	(Print Legibly) **Miles**

This report is a correct statement of the Auto Allowance due me as authorized by the Board of Education for use of my automobile on official business as an employee of the Saint Paul Public Schools. In addition, I certify that the owner of any vehicle used for this purpose carries the appropriate liability insurance as required by State Statute.

Total Miles	
Reimbursement	**$**

Employee Signature Date

Budget Administrator Signature Date

Budget code must be included to be processed.

Percent/ Amount	Fund	Org	Pro	Fin	Obj	Cou

Rev 110806