							MONTH						
1		MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES											
4	<del>(</del> )							VENDOR NO. (SOCIAL SECURITY NO.)			DOCUMENT NO.  DIRECT (ACH)  PAGE		
MONTHLY EXPENSE REPORT				,			AGENC'		PAGE				
EMPLOYEE NAME (LAST, FIRST)									HOME (CHECK)			OF	
HOME ADDRESS (Only needed if HOME (CHECK) is marked)					DEPARTMENT/DIVISION OR INSTITUTION			_ ` '					
OFFICE ADDRESS						WORK PHONE NO. UNIT/COUNTY							
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DATE	FROM/TO & PURPOSE	RET	TRAVEL	A	MILES	BREAKFAST	LUNCH	DINNER	LODGING	BUS/R.R./ AIR - CAR	MISC.*	TOTAL	
0,111	1110101110 41 6111 002	(X)	OPTION**	E	I IIII	01121147101	2011011	D	2000	RNTL EXP.	101100.	10.7.2	
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TOTALS FROM OTHER PAGES »													
TOTAL STANDARD (S) MILES »					AT \$0.500 PER MILE								
TOTAL FLEET (F) MILES »					AT \$0.260 PER MILE								
TOTAL RENTAL (R) MILES »						AT PER MILE							
TOTAL INSTATE  \$  \$					TOTAL REIMBURSABLE EXPENSE »								
DATE * EXPLANATION OF MISCELLANEOUS		ous						** EXPLANATION OF TRAVEL OPTION					
								(Choose all that apply for each trip)					
						1			1		ICLE NOT A		
								2	RENTAL VEHICLE NOT AVAILABLE				
								3	PROXIMITY OF STATE VEHICLE PROXIMITY OF RENTAL VEHICLE				
$\vdash$	<del>-  </del>				+			5	EMERGENCY/ANONYMITY (explain)				
							6						
					7 (a-e) EXCEPTIONS (refer to policy)								
I hereby certify that I have reviewed the above claim and that the expenses					I hereby certify the above claim is correct, that these expenses were necessary to conduct state								
					business, that payment has been made from personal funds for which I have not been reimbursed, nor will I receive from any source any payment for these expenses.								
APPROVAL SIGNATURE					CLAIMANT SIGNATURE				о одренвев.	DATE			
APPROVAL NAME (PLEASE PRINT OR TYPE)						CLAIMANT NAME (PLEASE PRINT OR TYPE)							
TITLE DATE APPRVD				TITLE OFFICIAL DOMICILE					OIL E				
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VERIFIED BY						DATE							