WEBB COUNTY
LOCAL MILEAGE CLAIM FORM

PERIOD COVERED: FROM _____ TO _____

EMPLOYEE : _____ **INVOICE NUMBER:** _____ **DEPARTMENT:** _____

EMPLOYEE'S VENDOR#: _____ **INVOICE DATE:** _____ **ACCOUNT NUMBER:** _____

DATE	TIME	DEPARTURE LOCATION	DESTINATION LOCATION	PURPOSE		ODOMETER START	ODOMETER END	MILEAGE
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0
								0

EMPLOYEE CERIFICATION:

I hereby certify that the above is true, correct and unpaid for travel incurred absolutely necessary in the discharge of my official duties.

EMPLOYEE SIGNATURE **DATE**

OFFICIAL/DEPARTMENT HEAD CERTIFICATION:

I am hereby presenting for payment expenses approved for my department for this fiscal year, which are absolutely necessary in the discharge of my official duties, and for which there is an available balance in my approved budget to this I certify. I also certify that this expenditure is proper, appropriate and that it complies with all federal, state and grant regulations and laws concerning the expenditure of these fund.

OFFICIAL'S SIGNATURE / TITLE **DATE**

TOTAL MILES 0

@ 57.5¢/ MILE

TOTAL DUE EMPLOYEE $ 0.00

FORM AP03 REV 1/ 20