Department of Human Services **Travel Expense Claim** For the month of: _____

TO: AMH
Attn: Travel Coordinator
500 Summer St E86
Salem, OR 97301

Management ☐
Employee ☐
Volunteer ☐
Brd/Commission ☐

Index (Cost Cntr) _____
If known - PCA _____
Client Case # PL _____

Official Duty Station: _____
What is your work schedule? _____
(ie 8-5) _____

Traveler SSN:		Your Complete Mailing Address:	
Print First Name	Print Last Name		Did you Receive a travel Advance?
			If "yes", how much:
Work Phone No.(area code & ext)			Advance # TA:

DATES AND DESTINATION				Mileage		Meals				Lodging	MISCELLANEOUS		
				RATE .575 1/1/2015									
Date	Travel Begins Use AM/PM	Travel Ends	Destination/Location/City	No. of Miles	Mileage Amount	Breakfast	Lunch	Dinner or prorate	Daily Total Meals	Receipt Required	Misc. Amount $$	Describe Misc Item (room tax, phone, parking)	REASON FOR TRAVEL (Be specific)
			TOTALS ON THIS PAGE										
			TOTALS FROM ATTACHED FORMS									Total Requested	
			GRAND TOTALS										

Select One (below)

I ◉ lid/will ○ did not/will not accept travel awards as a result of, or associated with this state business trip._____Initials. Completion of this block is mandatory. Travel expense reimbursement claims will not be processed if this block is left blank. Travel awards include, but may not be limited to, airline frequent flyer miles and hotel and car rental frequent customer awards or miles.

CLAIMANT SIGNATURE

Claimant's signature certifies that all reimbursements claimed are duty required expenses and that no part has been heretofore claimed or will be claimed from another source.

APPROVAL SIGNATURE / TITLE **DATE** **PRINT NAME OF APPROVER** **PHONE NUMBER**

Approval signature certifies that the expenses are for approved business travel and the amounts are correctly calculated.

For Financial Services Use Only

DHS 1297 (1/1/2015)