

# EMPLOYEE TRAVEL EXPENSE REPORT

THOSE AREAS THAT ARE SHADED MUST BE COMPLETED BY THE TRAVELER

1 Originating Agency <b>SUNY COLLEGE @ CORTLAND</b>		Orig. Agency Code <b>28170</b>		Interest Eligible (Y/N)	
Payment Date (MM/DD/YY)				Liability Date (MM/DD/YY)	
2 Payee ID	Additional	Zip Code	Route	Payee Amount	MIR Date (MM/DD/YY)
2 Payee Name (Last)	First Name	(MI)	(Suffix)	Ref/Inv. # (limit 14 additional spaces)	Ref/Inv.Date mm/dd/yy
3 Address: (to mail check to)(Street Address, City, State, Zip):				IRS Code	IRS AmIRS Amountunt
4 Business Purpose of Travel (be specific):				5 Official Work Station: (City, State, Zip)	
6 Destination Address: (Street Address, City, State, Zip):					
7 Date & Time of Departure	AM PM	8 Date & Time of Return	AM PM	9 Check if used: <input type="checkbox"/> Corp Card <input type="checkbox"/> Advance <input type="checkbox"/> Direct Bill	
10 Regular Work Hours:					

Section 1 - Indicate All Travel Expenses - Use detail sheet if necessary				Section 2 - Summary		
				TOTAL	Amount	
11 Lodging					A. Total travel expenses	
12 Transportation Expense					B. Subtract amount billed directly to agency-corp card	
13 Miscellaneous Expenses/Explanations					C. Subtract amount paid with Travel Advance	
14 Meals Document attached for multiple Overnight Per Diem @ \$ each = Per Diem Rates. Additional Breakfast @ \$ each + Additional Dinner @ \$ each = Day Trip Breakfast @ \$ each + Day Trip Dinner @ \$ each =					D. Other adjustments (specify)	
15 Total Mileage from attached AC 160 or Trip Calculator miles at <b>0.70</b> cents per mile					Total amount to be reimbursed to traveler/ (or if negative) total amount to be returned to agency (attach check)	
<b>Total Travel Expenses</b> Enter in Section 2 Line A						

PAYEE'S CERTIFICATION				STATE COMPTROLLER'S PRE AUDIT			
I hereby certify that the above account and schedules are just, true, and correct; that no part thereof has been paid, except as stated therein, and that the balance therein stated is actually due and owing, and that the amounts claimed were necessary and incurred in the performance of my authorized official duties.				Certified for payment by  _____			
Signature: _____ Date: _____ e-mail: _____ Work Phone: _____				For Agency Finance Office Use Only			
SUPERVISOR'S CERTIFICATION				I certify that this claim is correct and just and that this payment is approved			
I, the claimant's supervisor, certify this account has been examined and, to the best of my knowledge and belief, the amounts claimed were necessary for the performance of the claimant's authorized official duties.							
Supervisor's Signature: _____ Date: _____ Name & Title (Print/Type Legibly): _____							
By: _____ Authorized Signature				Title: _____ Date: _____			

EXPENDITURE						
Dept.	Account Number	Variable	Year	Object Code	Amount	TR Fiscal Control #