ORLEANS/NIAGARA
Board of Cooperative Educational Services

HOME HOSPITAL TEACHER
MILEAGE CLAIM FORM

Employee Name: _____ Date Submitted: _____

Address: _____ Month/Year: _____

_____ PO#: _____

Date	Location 1 Student Name or Site	Location 2 Student Name or Site	Location 3 Student Name or Site	Location 4 Student Name or Site	Location 5 Student Name or Site	Total Miles
Sample Entry						
1/2/2012	Jones	10 Smith	3 Roberts	5 Fish	10 Edwards	28

This form must be submitted to your supervisor monthly.

Attach list of complete student name and/or location addresses to this form.

Note: Final mileage form must be submitted on the last workday of the school year.

Total Miles	
Mileage Rate	
Total	

Supervisor Approval _____ Date _____