**RADY CHILDREN'S HOSPITAL**

**NON-EMPLOYEE TRAVEL EXPENSE REIMBURSEMENT FORM**

**NAME** _____ **TIME PERIOD:** **From** _____ **To** _____

**HOME MAILING ADDRESS** _____ **MAIL CODE** _____ **EXT.** _____

_____

**Mileage Rate**
1/1/2023-12/31/2023 $0.655 / mile

**This form should be completed for travel and related expenses only. Non-travel expenses must be submitted on a Non-Travel Expense Reimbursement Form. Reimbursements for ONLY mileage and related parking may be obtained using a Mileage Expense Reimbursement Form. Attach original receipts to this form. Refer to Children's Hospital and Health Center Travel Expense Reimbursement Policy.**

| GL Code | 688100 | | | 688600 | | 688300 | 688200 | 688200 | 688200 | 687000 | 688000 | 688000 | 688000 | 688000 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Airfare | | | Private Auto | | | | | | Registration | Taxi, Tolls, | | | | |
| Date | Airline | To/From | $ | # Miles | $ | Lodging | Breakfast | Lunch | Dinner | Fees | Parking | Phone | Tips | Other | Total |
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| **TOTAL** | N/A | N/A | | | | | | | | | | | | | |

**BUSINESS PURPOSE OF TRIP(S):**

**SUBMITTED BY:** _____ _____
(Signature) (Date)

**GL DISTRIBUTON AND ACCT: Please total expenses by GL and ACCT and obtain required approvals for each GL Distribution.**

| BU-DEPT-LOC-ACCT-FUND-PROJ BU-PROJ-ACTIVITY-RESOURCE-CAT | Total | Signature | APPROVED BY: Printed Name |
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**TOTAL** _____