CITY OF ORONOCO
EXPENSE REIMBURSEMENT REQUEST

DATE:_____ Total Reimbursement *(Expense + Mileage)* $ _____

NAME: _____

ADDRESS:_____

Function / Activity / Department: _____

_____

_____

DATE	DESCRIPTION	AMOUNT
	MILEAGE REIMBURSEMNT REQUEST :	
Miles:		
	2024 Rate X .67=	

I declare under penalties of law that this request for reimbursement is the true and correct amount expended by me and that no part of it has been paid and request reimbursement for same. Claimant is required to attach supporting document(s) and or invoice(s).

_____ _____

Signature of Claimant Signature of Supervisor (if necessary)

_____ _____

City Administrator Date

~ PO. Box 195 ~ Oronoco, MN 55960 ~ 507-367-4405 ~
Email: jbaker@oronoco.com