

Please complete the shaded areas.

CLAIMANT'S NAME		SSN OR EMPLOYEE NUMBER*		DEPARTMENT	
POSITION		CBID	DIVISION OR BUREAU		INDEX NUMBER
PEACE OFFICER		R/06	HUMAN RESOURCES		4754/16887
RESIDENCE ADDRESS*		HEADQUARTERS ADDRESS		TELEPHONE NUMBER	
		9838 OLD PLACERVILLE ROAD, SUITE B		(916) 255-3774	
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
			SACRAMENTO	CA	95827

(1) MONTH/YR	(2) DATE	(3) LOCATION	(4) LODGING	(5) MEALS			(6) INCIDENTALS	(7) TRANSPORTATION				(8) BUSINESS EXPENSE	(9) TOTAL EXPENSES FOR DAY
				BREAK-FAST	LUNCH	O.T., L/T, N/C, RELO, OR DINNER		(A) COST OF TRANS.	(B) TYPE USED	(C) CARFARE, TOLLS, PARKING	(D) PRIVATE CAR USE MILES		
			XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX			
(10) SUBTOTALS													
CLAIM TOTAL												\$	

(11) PURPOSE OF TRIP, REMARKS, AND DETAILS (Attach receipts/vouchers when required)

TB Testing is required under Penal Code Sections 6006.5 and 6007 as a condition of employment.

	PCA	PROJECT	WORK PHASE	OBJ AO	AMOUNT	TOTAL						
(12) NORMAL WORK HOURS				413								
(13) PRIVATE VEHICLE LICENSE No.												
(14) MILEAGE RATE CLAIMED												
AGENCY ACCOUNTING OFFICE USE ONLY												
PAID BY REV. FUND CHECK No.												
TOTALS												

(15) I HEREBY CERTIFY that the above is a true statement of the travel expenses incurred by me in accordance with DPA rules in the service of the State of California. If a privately owned vehicle was used, and if mileage rates exceed the minimum rate, I certify that the cost of operating the vehicle was equal to or greater than the rate claimed, and that I have met the requirements as prescribed by SAM Sections 0750, 0751, 0752, 0753, and 0754 pertaining to vehicle safety and seat belt usage.

CLAIMANT'S SIGNATURE	DATE	(16) SIGNATURE OF OFFICER APPROVING TRAVEL AND PAYMENT	DATE

(17) SIGNATURE AND TITLE OF AUTHORITY FOR SPECIAL EXPENSES (See Item 17 on reverse)	DATE