Health Services Association of California Community Colleges
TRAVEL REQUEST FORM

TRAVELER INFORMATION:

Name: ______________________________

Address: ______________________________

City: ____________________ State/Zip: ____________________

TRIP INFORMATION:

Purpose of Trip: (attach related information/email, etc) ____________________

____

Departure Date/Time: ______________________________

Return Date/Time: ______________________________

Airplane _______ Airport Bus _______ Personal Car ______ Other _____________

EXPENSE INFORMATION:

HSACCC will reimburse members for expenses up to ________, including mileage expenses for trips over ________ miles away, or airfare up to ________ as needed.

Ground Transportation: (current allowable I.R.S. rate) **SUB-TOTAL: $**____________

_________ Miles @ ________/mile = $__________
Bus / Airport Shuttle / Taxi = $__________
Bridge = $__________
Parking = $__________

Air Transportation **SUB-TOTAL: $**____________

Airline ______________________________
Fare ______________________________

Lodging **SUB-TOTAL: $**____________

Location: ______________________________
# of nights: ___________ @ Rate/day _______________

Other **SUB-TOTAL: $**____________

Registration:______________________ = $__________
Meals:___________________________ = $__________
Misc:____________________________ = $__________

Traveler's Signature: ______________________________

TOTAL EXPENSES BEING REQUESTED: $_________________

AMOUNT AUTHORIZED: $______________________ **DATE:** ______________________

SIGNATURE: ______________________________

NOTES: ______________________________