FOR FISCAL USE ONLY

FUND

DEPT/DIV

COST CENTER

| GRANT | SUB GRANT | OBJECT | AMOUNT |
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**STATE OF TENNESSEE** DEPT. HEALTH DIV.

**CLAIM FOR TRAVEL EXPENSES**

FOR PERIOD FROM _____ TO _____

THIS CLAIM MUST BE PREPARED IN ACCORDANCE WITH TRAVEL REGULATIONS
TYPE OR PREPARE IN INK

| DATE | PLACE LEFT | TIME LEFT AM/PM | PLACE ARRIVED | TIME ARRIVED AM/PM | TRANSPORTATION | | | | SUBSISTENCE | | | | OTHER EXPENSES | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | MILES | MILEAGE AMOUNT | AIRLINE/ OTHER | TAXI OR LIMO | LODGING | BREAK-FAST | LUNCH | DINNER | ITEMIZED, ATTACH RECEIPTS AND EXPLAIN | |
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| | | | | | | - | | | | | | | | - |
| TYPE OR PRINT COMPLETE HOM ADDRESS: | | | | TOTALS | 0 | 0.00 | - | - | - | - | - | - | - | - |

NAME: _____

ADDITIONAL EXPLANATION: One Time Payment

GROSS TOTAL -

LESS TEMP. TRAVEL ADVANCE # ( )

I CERTIFY THAT THIS CLAIM IS TRUE AND CORRECT. AMT. DUE CLAIMANT $ -

AMT. DUE STATE $

SIGNATURE

OFFICIAL STATION POSITION DATE

DATE OF PREVIOUS CLAIM _____

APPROVED DATE

ORIGINAL-DIV. OF ACCOUNTS DUPLICATE-FILE TRIPLICATE-CLAIMANT

APPROVED DATE

70FA-0080 (Rev. 8-88)