FORT BEND COUNTY
Travel Expense Reimbursement Report/Transmittal

Name: MARTHA HERNANDEZ **SSN or Vendor #** _____ **Department:** INDIGENT HEALTH CARE

Funding Source #1: 100640100 (Accounting Unit) | 63200 (Account Number) | _____ (Activity) if applicable | _____ (Reporting Category) if applicable

Funding Source #2: (if applicable) _____ (Accounting Unit) | 63200 (Account Number) | _____ (Activity) if applicable | _____ (Reporting Category) if applicable

Purpose of Travel: CIHCP STATE TRAINING **Destination:** AUSTIN, TX

Date/Time Departure of FBC 8.26.13 @ 8:00 A.M. **Date/Time Arrival at FBC** 8.28.13 @ 5 P.M.

Means of Transportation ☐ Personal Vehicle ☑ County Vehicle ☐ Airline **Rental Car at Destination** ☐ Yes ☑ No

Hotel Prepaid ☐ Yes ☑ No **Refund due from Hotel** ☐ Yes ☑ No **Cash Receipt Deposit #** _____

Any expenses reimbursed by another agency? (State) ☐ Yes ☑ No **Agency:** _____

Any expenses charged on the PCARD? ☑ Yes ☐ No **If Yes, list expenditures** _____

Proof of payment must be attached for items prepaid by check or on the Procurement Card (hotel, airfare, rental car, conf. registration etc.)

Date(s)	Merchant/Location/Description For Mileage Reimbursement list starting and ending destination	Mileage	Misc. Expenses
	Per Diem Total (if applicable)		
9.24.13	HOTEL CANCELATION FEE		388.70
	Total Miles	-	
	x Mileage Rate	0.565	
Out of State Approval Date by Commissioners' Court _____ (Attach copy of minutes with reimbursement)	Subtotals	$0.00 63200	$388.70 63200
	Total Reimbursement	**$388.70**	

The undersigned hereby certifies that mileage and expenses listed above were incurred on official county business only, and that reimbursement has not been received for any part thereof.

Employee Signature: _____ **Date:** 9.24.13

Department Head/ Elected Official Signature _____ **Date:** _____