Mileage Record for the Child & Adult Care Food Program

Traveler's Name: ______________________________ Travel Period: ______________________

Date	Time		Odometer		Origin / Destination	Purpose		Miles
	Start	End	Start	End	City / Provider Name	HV	Other (specify) / Comments	
							Total Miles	

Mileage Reimbursement Rate: X ___________

Total (this page): $ ___________

Certification: I certify that the mileage above is correct, conducted during official business, due and unpaid, and that the amount claimed herein is actually due according to law.

______________________________ ______________

Claimant Signature *Date*

Certification: As an official of the agency, I certify that the above mileage has been reviewed for reasonableness and allowability.

______________________________ ______________

Agency Official *Date*

Check Number: ____________________ *Check Date:* _________________