State of New York

EMPLOYEE REPORT OF TRAVEL EXPENSES AND CLAIM FOR PAYMENT

Agency Name: 2858 SUNY College of Optometry

Employee ID

Last Name First Name MI

Address

City State Zip Normal Work Hours

Business Purpose: Travel Destination - Include Street Address and Zip Code

Travel Start Date and Time: Travel End Date and Time: Check if used:

[ ] Corp Card  [ ] Advance  [ ] Direct Bill

Travel Description

Departure Point

1. Indicate All Travel Expenses

If more space is required in any section, use the associated detail form (number shown in parentheses below)

<table>
<thead>
<tr>
<th>Description</th>
<th>Overnight Per Day</th>
<th>Per-Day</th>
<th>Additional Breakfast</th>
<th>Additional Dinner</th>
<th>Per-Day</th>
<th>Day Trip Breakfast</th>
<th>Day Trip Dinner</th>
<th>Per-Day</th>
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</thead>
<tbody>
<tr>
<td>Lodging</td>
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<tr>
<td>Transportation (AC3259-S)</td>
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<tr>
<td>Meals (AC3258-S)</td>
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<td>Mileage Claimed (AC160-S)</td>
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<tr>
<td>Incidental Expenses – List (AC3259-S)</td>
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</table>

Totals

A. Total Travel Expenses

B. Subtract Amount Paid with Travel Advance

C. Subtract Amount Billed to Corp Card (AC3256-S)

D. Other Direct Bill to Agency (Specify)

E. Other Adjustments (Specify)

Total Travel Expenses – Enter in Section 2 Line A: Total Amount Claimed

Traveler’s Certification

I, the traveler, certify that the amounts claimed were necessary and incurred in the performance of my official duties.

Signature     Title     Date

Supervisor’s Certification (if required)

I, the claimant’s supervisor, certify that this account has been examined and to the best of my knowledge and belief, the amounts claimed therein were necessary for the performance of the claimant’s authorized official duties.

Signature     Title     Date

EXPENDITURE

Dept.  Account  Year  Object Code  Amount  Object Code  TR Fiscal Control #