KYSOS Mileage Reimbursement Form

***PROGRAM NAME*: _____**

***PROGRAM DATE(S):* _____**

Mileage * (round trip)	
Mileage Cost (round trip mileage x $0.70)	
Tolls/Parking Charges (if applicable)	
Hotel Charge	
Total Amount Requested for Reimbursement (mileage cost + tolls/parking charges + hotel)	

**(Mileage will be reimbursed for those traveling from the hospital to the event. Please use the hospital address as starting point. Mileage is reimbursed at $0.70 mile).*

Name (please print)	
Signature	
Hospital	
Home Mailing Address	

Check should be made out in the name of _____

Please scan and email completed form to:

Emily Henderson, KY SOS
ehenderson@kyha.com