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STATE OF MISSOURI

MONTHLY EXPENSE REPORT

FOR MONTH OF

PAGE ______ OF ______

THE WHITE AREAS MUST BE COMPLETED. THE GRAY AREAS ARE OPTIONAL FOR AGENCY USE. SEE INSTRUCTIONS ON BACK.

DEPARTMENT/DIVISION OR INSTITUTION	
EMPLOYEE NAME (LAST, FIRST)	VENDOR CODE (SOCIAL SECURITY NUMBER)

OFFICE ADDRESS	WORK PHONE NO.	UNIT/COUNTY	LOCATION CODE OR DOCUMENT NO.

DATE	FROM/TO & PURPOSE	OVER-NIGHT STAY (X)	RET (X)	STANDARD MILES	FLEET MILES	BREAK-FAST	LUNCH	DINNER	LODGING	OTHER*	
											0.00
											0.00
											0.00
											0.00
											0.00
											0.00
											0.00
											0.00
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											0.00
											0.00
											0.00
											0.00
TOTALS OF ABOVE				0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
TOTALS FROM OTHER PAGES											0.00
TOTAL STANDARD MILES				0.00			AT 0.370	¢ PER MILE			0.00
TOTAL FLEET MILES				0.00			AT 0.260	¢ PER MILE			0.00

TOTAL INSTATE	TOTAL OUTSTATE	TOTAL REIMBURSABLE EXPENSE	
$	$		0.00

DATE	*EXPLANATION OF OTHER				

I hereby certify the above claim is correct, that these expenses were necessary to conduct state business, that payment has been made from personal funds for which I have not been reimbursed, nor will I receive from any source any payment for these expenses.

APPROVAL SIGNATURE		CLAIMANT SIGNATURE		DATE
TITLE	DATE APPROVED	TITLE	OFFICIAL DOMICILE	

	FUND	AGCY	ORG/SUB	APPR UNIT	ACTIVITY	FUNCTION	OBJ/SUB	JOB NUMBER	REP CAT	AMOUNT
VERIFIED BY AND DATE			/				/			
			/				/			
CODED BY AND DATE			/				/			
			/				/			
			/				/			
CK CATEGORY			/				/			
			/				/			
			/				/			