



STATE OF MISSOURI
MONTHLY EXPENSE REPORT

FOR MONTH OF _____ PAGE _____ OF _____
 DEPARTMENT/DIVISION OR INSTITUTION _____

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

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*	TOTAL

TOTALS OF ABOVE ▶											
TOTALS FROM OTHER PAGES ▶											
TOTAL STANDARD MILES ▶											
TOTAL FLEET MILES ▶											

TOTAL INSTATE \$	TOTAL OUTSTATE \$	TOTAL REIMBURSABLE EXPENSE ▶	
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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

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