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PAID PPE:	
INITIAL:	

COUNTY OF SONOMA
PERSONAL AUTOMOBILE MILEAGE CLAIM

DEPARTMENT: _____

EMPLOYEE: _____ **EMPLOYEE ID #:** _____

DATE	DESCRIPTION: (PASSENGER NAME(S), PURPOSE & DESTINATION)	MILES DRIVEN
		0.

Mileage Rate effective 1/01/2020

☐ Request for Staff Development Reimbursement -- Attach this form to your Staff Development Application

TOTAL MILES DRIVEN:	0.0
MILEAGE RATE:	.575
TOTAL REIMBURSEMENT:	0.00

I certify that the mileage claimed was actual and for official business of the Department, and that I have a valid driver's license and adequate insurance to meet County requirements. I am requesting reimbursement as an employee and acknowledge that this reimbursement will be processed through the County's Payroll System and must be submitted for payment no later than 90 days following the date of travel.

_____ _____

Date Employee Signature

_____ _____

Date Authorized Approval