Professional Day Reimbursement Request

Maroa Forsyth C. U.S.D. #2

Name _____ Date of Request_____

_____ Administration Requested I Attend _____ I Requested to Attend

Date of Conference	Name of Conference	Registration Fees Paid *	Miles Driven**	Total Reimbursement Requested

* Registration Fee not to exceed $125.00 ** Mileage not to exceed 100 miles, paid at IRS rate ($.55)

Please provide copies of any receipts or certificates of completion that are available

Please provide a 2-3 sentence summary of the conference highlights

_____

_____

_____

_____

Employee Signature _____

For Office Use Only

Date Received _____

Date Processed _____

Check # _____