CLAIM FOR REIMBURSEMENT FOR EXPENDITURES ON OFFICIAL BUSINESS

1. DEPARTMENT OR ESTABLISHMENT, BUREAU, DIVISION OR OFFICE

2. VOUCHER NUMBER

3. SCHEDULE NUMBER

Read the Privacy Act Statement on the back of this form.

5. PAID BY

4. CLAIMANT

a. NAME *(Last, first, middle initial)*

b. SOCIAL SECURITY NUMBER

c. MAILING ADDRESS *(Include ZIP Code)*

d. OFFICE TELEPHONE NUMBER

6. EXPENDITURES *(If fare or toll claimed in column (g) exceeds charge for one person, show in column (h) the number of additional persons which accompanied the claimant.)*

Show appropriate code in column (b):
A - Local Travel
B - Telephone or Telegraph
C - Other expenses *(itemized)*
D. Funeral Honors Detail
E. Specialty Care

(Explain expenditures in specific detail.)

DATE (a)	CODE (b)	(c) FROM	(d) TO	MILEAGE RATE ¢ / NUMBER OF MILES (e)	AMOUNT CLAIMED: MILEAGE (f)	FARE OR TOLL (g)	ADD PERSONS (h)	TIPS AND MISCELLANEOUS (i)
If additional space is required continue on the back.			**SUBTOTALS CARRIED FORWARD FROM THE BACK**					
			TOTALS					

7. AMOUNT CLAIMED *(Total of columns (f), (g) and (i).)* ▶ **$**

8. This claim is approved. Long distance telephone calls, if shown, are certified as necessary in the interest of the Government. *(Note: If long distance calls are included, the approving official must have been authorized in writing, by the head of the department or agency to so certify (31 U.S.C. 680a).)*

Sign Original Only

APPROVING OFFICIAL SIGN HERE ▶ DATE

9. This claim is certified correct and proper for payment.

Sign Original Only

AUTHORIZED CERTIFYING OFFICER SIGN HERE ▶ DATE

10. I certify that this claim is true and correct to the best of my knowledge and belief and that payment or credit has not been received by me.

Sign Original Only

CLAIMANT SIGN HERE ▶ DATE

11. CASH PAYMENT RECEIPT

a. PAYEE *(Signature)*

b. DATE RECEIVED

c. AMOUNT **$**

12. PAYMENT MADE BY CHECK NUMBER

ACCOUNTING CLASSIFICATION

6. EXPENDITURES -- Continued

Show appropriate code in column (b):
A - Local Travel
B - Telephone or Telegraph
C - Other expenses *(itemized)*
D. Funeral Honors Detail
E. Specialty Care

DATE (a)	CODE (b)	(Explain expenditures in specific detail.) (c) FROM	(d) TO	MILEAGE RATE ¢ / NUMBER OF MILES (e)	AMOUNT CLAIMED: MILEAGE (f)	FARE OR TOLL (g)	ADD PERSONS (h)	TIPS AND MISCELLANEOUS (i)
Total each column and enter on the front, subtotal line. ▶								

In compliance with the Privacy Act of 1974, the following information is provided: Solicitation of the information on this form is authorized by Executive Order 11609 of July 22, 1971, Executive Order 11012 of March 27, 1962, Executive Order 9397 of November 22, 1943, and 26 U.S.C. 6011(b) and 6109. The primary purpose of the requested information is to determine payment of reimbursements from the Government. The information will be used by Federal agency officers and employees who have a need for the information in the performance of their official duties. The information may be disclosed to appropriate Federal, State, Local, or Foreign agencies, when relevant to civil, criminal, or regulatory investigations or prosecutions, or when pursuant to a requirement by this agency in connection with the hiring or firing of an employee, the issuance of a security clearance, or investigations of the performance of official duty while in Government service. Your Social Security Number (SSN) is solicited under the authority of the Internal Revenue Code (26 U.S.C. 6011(b) and 6109) and Executive Order 9397, November 22, 1943, for use as a taxpayer and/or employee identification number. Disclosure is MANDATORY on vouchers claiming payment or reimbursement which is, or may be, taxable income. Disclosure of your SSN and other requested information is voluntary in all other instances. Failure to provide the information (other than SSN) required to support the claim may result in delay or loss of reimbursement.