



SOUTH TEXAS COLLEGE

**EMPLOYEE IN-DISTRICT MILEAGE REIMBURSEMENT
AND AUTHORIZATION FORM**

Name: _____ A #: _____ Date: _____

Title _____

Home Base: _____

Department _____

Organization to charge: _____ Organization name: _____

FACULTY (Regular and Adjunct)

Semester: Fall Spring Summer I Summer II Summer III

Begin Date: _____ End Date: _____

Destination(s): _____ Purpose: _____

Estimated miles for semester: _____ miles @ \$0.58 \$ _____

COMPLETE THIS PORTION ONLY IF REQUESTING REIMBURSEMENT FOR COMMUTING

From: _____ To: _____ Miles of commute: _____ @ \$0.58 \$ _____

APPROVAL: _____ Vice-President _____ Employee Signature _____

Note: Payment for commuting miles is considered taxable income.

ALL OTHER - CLASSIFIED, PROFESSIONAL SUPPORT, ADMINISTRATIVE, EXECUTIVE

Fiscal Year: _____ Begin Date: _____ End Date: _____

Destination(s): _____ Purpose: _____

Estimated miles for fiscal year: _____ miles @ \$0.58 \$ _____

I have read and understand the employee mileage reimbursement procedures. I have attached current proof of insurance and current Texas driver's license and will, upon expiration of coverage period, submit proof of insurance renewal. I certify that the above mentioned headquarters is correct and will be use to determine mileage calculation.

Signature (Requester) _____

Date _____

Immediate Supervisor _____

Telephone Number _____

Financial Manager/Division Dean/Department Director _____

Date _____

Business Office _____ Date _____

Distribution
Business Office (Original)
Department (Copy)

- ★ **SUBMIT THIS FORM PRIOR TO BEGINNING OF SEMESTER (FACULTY) OR FISCAL YEAR (ALL OTHER).**
- ★ **CURRENT PROOF OF INSURANCE MUST BE ATTACHED.**
- ★ **PROOF OF INSURANCE RENEWALS MUST BE FORWARDED TO THE BUSINESS OFFICE.**