Siouxland Mental Health Services, Inc.
Employee Expense Report (Attach all Receipts)

Name: _____ Period: From _____ To _____

1.) Mileage Expense

Date	Business Purpose	Program	Parking & Other	Number of Miles

Total Miles _____

X .40/Mile

Total Mileage Expenses $ $ $

2.) Travel Expense

Date	Place & Business Purpose	Lodging	Meals	Misc.	Totals

Total Travel Expenses $ $ $ $

3.) Other Expenses

Date	Description	Amount

Total Other Expenses $

Grand Totals

Total #1 M.E.	$
Total #2 T.E.	$
Total #3 O.E.	$
Less (Describe): _____	$
Total Due Employee	$

Employees Signature: _____ Date: _____

Supervisors Approval: _____ Date: _____