REQUEST FOR REIMBURSEMENT/NON-STATE EMPLOYEE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
FINANCE
SFN 1765 (6-2023)

Clear Fields

INSTRUCTIONS: To be used by non-state employees for reimbursement i.e. travel, workshop, registration, purchase of service, payment according to state rates and regulations.

Vendor Name:		
Address Line 1:		
Line 2:		
Line 3:		
City:	State:	Zip Code:

Is this the final reimbursement request for this contract? ☐ Yes ☐ No

PAYEE CERTIFICATION

I CERTIFY THIS BILL TO BE TRUE AND CORRECT

Payee Signature:

Date:

Payee Telephone Number:

DEPARTMENT APPROVAL

Program Director
By:

Date:

Division/Section Director
By:

Date:

Liaison Accountant
By:

Date:

DISTRIBUTION:
Finance - returned with check
Vendor - retain copy

CONTRACT INFORMATION

Description of Service:

Contract Number:

Contract Period:

From: To:

Billing Period:

From: To:

REIMBURSABLE EXPENSES	TOTALS
Name of Workshop/Meeting - Date - Location	
Date and Time of Leaving Home Station (Show A.M. or P.M.)	
Date and Time of Return to Home Station (Show A.M. or P.M.)	
Lodging (Attach Receipts)	
Meals (Will be based on state rates)	
Mileage (Use actual odometer reading or map miles). Show roundtrip miles at state rate. Number of Miles x Rate:	$0.00
Air Fare (Attach Receipts)	
Registration Fees (Attach Receipt)	
Other Expenses (Explain or Attach Receipts)	
TOTAL REIMBURSABLE EXPENSES	**$0.00**

PURCHASE OF SERVICE

DAY	UNIT	DAY	UNIT	DAY	UNIT	DAY	UNIT	DAY	UNIT	DAY	UNIT	DAY	UNIT

Total No. of Units 0 **X Unit Rate** _____ **= Total Purchase of Service** $

FINANCE USE ONLY

TOTAL REIMBURSABLE EXPENSES AND TOTAL PURCHASE OF SERVICES TO BE PAID $ **$0.00**

REF LINE	Accounting Period Date	Speed Chart	Dept. ID	Account	Class	Fund	Project ID	Activity ID	Resource Type	Resource Category	TRANSACTION AMOUNT