

Professional Day Reimbursement Request

Maroa-Forsyth CUSD#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 \$200.00

Mileage not to exceed 100 miles, pay current IRS rate

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# _____