



Reimbursement Form

Council of State Archivists
PO Box 2508
Albany, NY 12220-0508
travel@statearchivists.org

FOR CoSA USE ONLY

Approved by: _____

Budget code: _____ Amount: _____

Budget code: _____ Amount: _____

Make reimbursement check payable to:

Name of Individual *or* Agency: _____ Phone: _____

Mail payment to:

Address: _____

City/State/Zip: _____

Reimbursement Information:

Reason for reimbursement: _____

Travel location (if applicable): _____ Travel dates (if applicable): _____

DATE	MILEAGE @ 55¢ / MILE	AIRFARE	TAXI/ SHUTTLE	PARKING	HOTEL	DAILY MEALS	OTHER AMOUNT	OTHER DESCRIPTION	DAILY TOTAL
TOTAL REIMBURSEMENT:									

I certify that the costs are just and correct, and that they were incurred in connection with my activities or responsibilities pertaining to CoSA.

Claimant signature: _____ Date: _____