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PAID PPE:	
INITIAL:	

COUNTY OF SONOMA
PERSONAL AUTOMOBILE MILEAGE CLAIM

DEPARTMENT: _____

EMPLOYEE: _____ **EMPLOYEE ID #:** _____

DATE	DESCRIPTION: (PASSENGER NAME(S), PURPOSE & DESTINATION)	MILES DRIVEN

Mileage Rate effective 7/01/2011

TOTAL MILES DRIVEN:	0.0
MILEAGE RATE:	0.555
TOTAL REIMBURSEMENT:	0.00

I certify that the mileage claimed was actual and for official business of the Department, and that I have a valid driver's license and adequate insurance to meet County requirements. I am requesting reimbursement as an employee and acknowledge that this reimbursement will be processed through the County's Payroll System.

_____ _____

Date Employee Signature

_____ _____

Date Authorized Approval