1. Form Typed or Written in Ink
2. All receipts must be attached

COUNTY OF LAKE

TRAVEL EXPENSE CLAIM

4/3/23 per Findell

Claimant Masdeo, Jacob Employee No. 321/709

Mailing Address 10011 El Dorado way Folsom CA 95451 Department No. 2301

Leave Date: 4-1-23 Time: 1530 Return Date: 4-2-23 Time: 0830

Destination Sutter Roseville Medical Plaza Drive Roseville CA 95661

Purpose Hospital Coverage

TRANSPORTATION ____ (Priv Car/Air Miles) x $0. ____ (Rate) = $ ____ (Amount) Fares $ ____ (Public Trans)

Other/Identify $ ____ (Amount) 1) ____ (Receipted)

2) ____ (Receipted)

Other/Identify $ ____ (Amount) 1) ____ (Allowable Unreceipted)

MEALS – PER DIEM (Travel Policy — Sec 2.1) $ 14.00 (Breakfast) x2 (No) $ 10.00 (Lunch) 1 (No) $ 34.00 (Dinner) +2 (No)

MEALS – ACTUAL (Travel Policy — Sec 4.1) $ ____ (Breakfast) ____ (No) $ ____ (Lunch) ____ (No) $ ____ (Dinner) ____ (No)

LODGING – ACTUAL (Travel Policy — Sec 4.1) $ ____ (Amount) ____ (No. of Days)

*If an advance was received, the travel expense form is due within 10 working days of your return. Failure to comply with this requirement will result in the ineligibility for future advances.

Total Reimbursement Claimed $ 58.00

Less Travel Advance* ____ ____ (Date of Advance)

Total Reimbursement Due $ 58.00

2950

I certify under the penalty of perjury that the within claim and the items as therein set out are true and correct, that no part thereof has heretofore been paid and that the amount therein is justly due me and that the same is presented within 60 days of the date on which expenses were incurred inclusive of required receipts, unless an advance was received (see above*).

I further certify the above meets all provisions of the County of Lake Travel Policy and that there are sufficient funds and budget appropriations to support this claim. Claim is hereby approved for the above total.

Claimant's Signature 5-3-23 Date

Authorized and Approved by Department Head Date

Vendor No. (7)	Invoice # (15)	Description (25)		
Fund (000)	Dept (0000)	Account (000.00-00)	Amount $	Project # (6)

****

Verified/Approved for Payment:

Jenavive Herrington, Auditor-Controller By ____ (Deputy Auditor) ____ (Date)

E:\FORMS\ACCOUNTS PAYABLE\TRVL EXP CLAIM

Revised Dec 2022

1. Form Typed or Written in Ink
2. All receipts must be attached

COUNTY OF LAKE

TRAVEL EXPENSE CLAIM

4/8/23 per Findley

Claimant Maddio, Jacob Employee No. 321/709

Mailing Address 10011 El Dorado Way Folsom CA 95451 Department No. 2301

Leave Date: 4-6-23 Time: 1530 Return Date: 4-8-23 Time: 0830

Destination Sutter Roseville 1 Medical Plaza Drive Roseville CA 95661

Purpose Hospital Coverage

TRANSPORTATION ____ (Priv Car/Air Miles) x $0. ____ (Rate) = $ ____ (Amount) Fares $ ____ (Public Trans)

Other/Identify $ ____ (Amount) 1) ____ (Receipted)

2) ____ (Receipted)

Other/Identify $ ____ (Amount) 1) ____ (Allowable Unreceipted)

MEALS – PER DIEM (Travel Policy — Sec 2.1)	$ 14.00 (Breakfast)	x2 (No)	$ 10.00 (Lunch)	x1 (No)	$ 34.00 (Dinner)	2 (No)
MEALS – ACTUAL (Travel Policy — Sec 4.1)	$ ____ (Breakfast)	____ (No)	$ ____ (Lunch)	____ (No)	$ ____ (Dinner)	____ (No)

LODGING – ACTUAL (Travel Policy — Sec 4.1) $ ____ (Amount) ____ (No. of Days)

*If an advance was received, the travel expense form is due within 10 working days of your return. Failure to comply with this requirement will result in the ineligibility for future advances.

Total Reimbursement Claimed $ 58.00

Less Travel Advance* ____ (Date of Advance)

Total Reimbursement Due $ 58.00

2950

I certify under the penalty of perjury that the within claim and the items as therein set out are true and correct, that no part thereof has heretofore been paid and that the amount therein is justly due me and that the same is presented within 60 days of the date on which expenses were incurred inclusive of required receipts, unless an advance was received (see above*).

I further certify the above meets all provisions of the County of Lake Travel Policy and that there are sufficient funds and budget appropriations to support this claim. Claim is hereby approved for the above total.

Claimant's Signature 5-3-23 Date

Authorized and Approved by Department Head Date

Vendor No. (7)	Invoice # (15)	Description (25)		
Fund (000)	Dept (0000)	Account (000.00-00)	Amount $	Project # (6)

****

Verified/Approved for Payment:

Jenavive Herrington, Auditor-Controller By ____ (Deputy Auditor) ____ (Date)

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Revised Dec 2022

1. Form Typed or Written in Ink
2. All receipts must be attached

COUNTY OF LAKE

TRAVEL EXPENSE CLAIM

Claimant Mastro, Jacob Employee No. 321/704

Mailing Address 10011 El Dorado Way Kelseyville CA 95451 Department No. 2301

Leave Date: 4-9-23 Time: 1530 Return Date: 4-11-23 Time: 0830

Destination Sutter Roseville 1 medical Plaza Drive Roseville CA 95661

Purpose Hospital Coverage

TRANSPORTATION ____ (Priv Car/Air Miles) x $0. ____ (Rate) = $ ____ (Amount) Fares $ ____ (Public Trans)

Other/Identify $ ____ (Amount) 1) ____ (Receipted)

2) ____ (Receipted)

Other/Identify $ ____ (Amount) 1) ____ (Allowable Unreceipted)

MEALS – PER DIEM (Travel Policy — Sec 2.1) $ 14.00 (Breakfast) x 2 (No) $ 10.00 (Lunch) x 1 (No) $ 34.00 (Dinner) 2 (No)

MEALS – ACTUAL (Travel Policy — Sec 4.1) $ ____ (Breakfast) ____ (No) $ ____ (Lunch) ____ (No) $ ____ (Dinner) ____ (No)

LODGING – ACTUAL (Travel Policy — Sec 4.1) $ ____ (Amount) ____ (No. of Days)

*If an advance was received, the travel expense form is due within 10 working days of your return. Failure to comply with this requirement will result in the ineligibility for future advances.

Total Reimbursement Claimed $ 58.00

Less Travel Advance* ____ ____ (Date of Advance)

Total Reimbursement Due $ 58.00

2950

I certify under the penalty of perjury that the within claim and the items as therein set out are true and correct, that no part thereof has heretofore been paid and that the amount therein is justly due me and that the same is presented within 60 days of the date on which expenses were incurred inclusive of required receipts, unless an advance was received (see above*).

I further certify the above meets all provisions of the County of Lake Travel Policy and that there are sufficient funds and budget appropriations to support this claim. Claim is hereby approved for the above total.

Claimant's Signature 5-3-23 Date

Authorized and Approved by Department Head Date

Vendor No. (7)	Invoice # (15)	Description (25)		
Fund (000)	Dept (0000)	Account (000.00-00)	Amount $	Project # (6)

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Verified/Approved for Payment:

Jenavive Herrington, Auditor-Controller By ____ (Deputy Auditor) ____ (Date)

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Revised Dec 2022

1. Form Typed or Written in Ink
2. All receipts must be attached

COUNTY OF LAKE

TRAVEL EXPENSE CLAIM

Claimant Masden, Jacob Employee No. 321709

Mailing Address 10011 Eldorado way Nekeyville CA 95451 Department No. 2301

Leave Date: 04-15-23 Time: 1530 Return Date: 04-16-23 Time: 0600

Destination Sutter Roseville 1 medical plaza Drive Roseville CA 95661

Purpose Hospital Coverage

TRANSPORTATION ____ (Priv Car/Air Miles) x $0. ____ (Rate) = $ ____ (Amount) Fares $ ____ (Public Trans)

Other/Identify $ ____ (Amount) 1) ____ (Receipted)

2) ____ (Receipted)

Other/Identify $ ____ (Amount) 1) ____ (Allowable Unreceipted)

MEALS – PER DIEM (Travel Policy — Sec 2.1) $ 7.00 (Breakfast) 1 (No) $ ____ (Lunch) X (No) $ 17.00 (Dinner) X 1 (No)

MEALS – ACTUAL (Travel Policy — Sec 4.1) $ ____ (Breakfast) ____ (No) $ ____ (Lunch) ____ (No) $ ____ (Dinner) ____ (No)

LODGING – ACTUAL (Travel Policy — Sec 4.1) $ ____ (Amount) ____ (No. of Days)

*If an advance was received, the travel expense form is due within 10 working days of your return. Failure to comply with this requirement will result in the ineligibility for future advances.

Total Reimbursement Claimed $ 24.00

Less Travel Advance* ____ (Date of Advance)

Total Reimbursement Due $ 24.00

2950

I certify under the penalty of perjury that the within claim and the items as therein set out are true and correct, that no part thereof has heretofore been paid and that the amount therein is justly due me and that the same is presented within 60 days of the date on which expenses were incurred inclusive of required receipts, unless an advance was received (see above*).

I further certify the above meets all provisions of the County of Lake Travel Policy and that there are sufficient funds and budget appropriations to support this claim. Claim is hereby approved for the above total.

Claimant's Signature 5-3-23 Date

Authorized and Approved by Department Head Date

Vendor No. (7)	Invoice # (15)	Description (25)		
Fund (000)	Dept (0000)	Account (000.00-00)	Amount $	Project # (6)

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Verified/Approved for Payment:

Jenavive Herrington, Auditor-Controller By ____ (Deputy Auditor) ____ (Date)

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Revised Dec 2022

1. Form Typed or Written in Ink
2. All receipts must be attached

COUNTY OF LAKE

TRAVEL EXPENSE CLAIM

4/1/23 per Findley

Claimant Daniel Constancio Employee No. 50747

Mailing Address 3465 Lakeshore Blvd, Lakeport Ca. 95453 Department No. 2301

Leave Date: 3-28-2023 Time: 1530 Return Date: 3-31-2023 Time: 0830

Destination Sutter Roseville Medical Center

Purpose Supervising Inmate

TRANSPORTATION _____ (Priv Car/Air Miles) x $0. _____ (Rate) = $ _____ (Amount) Fares $ _____ (Public Trans)

Other/Identify $ _____ (Amount) 1) _____ (Receipted)

2) _____ (Receipted)

Other/Identify $ _____ (Amount) 1) _____ (Allowable Unreceipted)

MEALS – PER DIEM (Travel Policy — Sec 2.1) $ 28 00 (Breakfast) 4 (No) $ 30 00 (Lunch) 4 (No) $ 68.00 (Dinner) 4 (No)

MEALS – ACTUAL (Travel Policy — Sec 4.1) $ _____ (Breakfast) _____ (No) $ _____ (Lunch) _____ (No) $ _____ (Dinner) _____ (No)

LODGING – ACTUAL (Travel Policy — Sec 4.1) $ _____ (Amount) _____ (No. of Days)

*If an advance was received, the travel expense form is due within 10 working days of your return. Failure to comply with this requirement will result in the ineligibility for future advances.

Total Reimbursement Claimed $ 126.00

Less Travel Advance* _____ _____ (Date of Advance)

Total Reimbursement Due $ 126.00

2950

I certify under the penalty of perjury that the within claim and the items as therein set out are true and correct, that no part thereof has heretofore been paid and that the amount therein is justly due me and that the same is presented within 60 days of the date on which expenses were incurred inclusive of required receipts, unless an advance was received (see above*).

Daniel Constancio 5-2-2023
Claimant's Signature Date

I further certify the above meets all provisions of the County of Lake Travel Policy and that there are sufficient funds and budget appropriations to support this claim. Claim is hereby approved for the above total.

_____ _____
Authorized and Approved by Department Head Date

Vendor No. (7)	Invoice # (15)	Description (25)		
Fund (000)	Dept (0000)	Account (000.00-00)	Amount $	Project # (6)

****

Verified/Approved for Payment:

Jenavive Herrington, Auditor-Controller By _____ (Deputy Auditor) _____ (Date)

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Revised Dec 2022

1. Form Typed or Written in Ink
2. All receipts must be attached

COUNTY OF LAKE

TRAVEL EXPENSE CLAIM

4/6/23 per Findley

Claimant Daniel Constancio Employee No. 50747

Mailing Address 3465 Lakeshore Blvd, Lakeport Ca 95453 Department No. 2301

Leave Date: 4-2-23 Time: 1530 Return Date: 4-5-23 Time: 0830

Destination Sutter Roseville Medical Center

Purpose Supervising Inmate.

TRANSPORTATION _____ (Priv Car/Air Miles) x $0. _____ (Rate) = $ _____ (Amount) Fares $ _____ (Public Trans)

Other/Identify $ _____ (Amount) 1) _____ (Receipted)

2) _____ (Receipted)

Other/Identify $ _____ (Amount) 1) _____ (Allowable Unreceipted)

MEALS – PER DIEM (Travel Policy — Sec 2.1)	$ 28.00 (Breakfast)	4 (No)	$ 30.00 (Lunch)	3 (No)	$ 68.00 (Dinner)	4 (No)
MEALS – ACTUAL (Travel Policy — Sec 4.1)	$ _____ (Breakfast)	_____ (No)	$ _____ (Lunch)	_____ (No)	$ _____ (Dinner)	_____ (No)

LODGING – ACTUAL (Travel Policy — Sec 4.1) $ _____ (Amount) _____ (No. of Days)

*If an advance was received, the travel expense form is due within 10 working days of your return. Failure to comply with this requirement will result in the ineligibility for future advances.

Total Reimbursement Claimed $ 126.00

Less Travel Advance* _____ (Date of Advance)

Total Reimbursement Due $ 126.00 2950

I certify under the penalty of perjury that the within claim and the items as therein set out are true and correct, that no part thereof has heretofore been paid and that the amount therein is justly due me and that the same is presented within 60 days of the date on which expenses were incurred inclusive of required receipts, unless an advance was received (see above*).

I further certify the above meets all provisions of the County of Lake Travel Policy and that there are sufficient funds and budget appropriations to support this claim. Claim is hereby approved for the above total.

Daniel Constancio 4-19-23
Claimant's Signature Date

_____ _____
Authorized and Approved by Department Head Date

Vendor No. (7)	Invoice # (15)	Description (25)		
Fund (000)	Dept (0000)	Account (000.00-00)	Amount $	Project # (6)

****

Verified/Approved for Payment:

Jenavive Herrington, Auditor-Controller By _____ (Deputy Auditor) _____ (Date)

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Revised Dec 2022