Form Typed or Written in Ink
 All receipts must be attached

COUNTY OF LAKE

TRAVEL EXPENSE CLAIM

Claimant Saul Sanabr	ia					_ Emp	loyee	No	
Mailing Address						Depa	artmen	it No.	5321
Leave Date: 10/07	7/2017 Time	e:0400 hrs	Return	Date	:10/13/2017	Time	e:	2100 h	rs
D	estination Rivers	side							
	Purpose Attend	d CACVSO Conf	ference						
TRANSPORTATION		x \$0.			= \$	F	ares \$		
	(Priv Car/Air M		(Rate)		= \$(Amount)		(Public	Trans)
Other/Ident	ify \$	28.33 (Amount)		1)	Parking	(D	• + 1)		
		(Amount)				(Rece	eipted)		
				2)					
Other/Ident			1)		,	eipted)			
Other/Identify \$(Amount)				1)	(Allowable Unreceipted)				
MEALS – PER DIEM		.00	0	\$.00	0	\$:	.00	00
(Travel Policy — Sec 2.1	(Bre	eakfast)	(No)		(Lunch)	(No)		(Dinner)	(No)
MEALS ACTUAL	\$ 4	2.00	6	\$	60.00	6	\$	102.00	6
(Travel Policy — Sec 4.1		eakfast)	(No)		(Lunch)	(No)	-	(Dinner)	(No)
LODGING – ACTUAL (Travel Policy — Sec 4.1)	\$	725.12 (Amount)			6 (No. of Days				
*If an advance was recei	ived, the Tota	l Reimbursement	Claimed	\$	957.45				
travel expense form is due within 10 working days of your return.		Less Travel	Advance*		725.12)	NA	
Failure to comply with trequirement will result	in the							(Date of Ad	vance)
ineligibility for future	e advances.	Total Reimbursen	nent Due	\$	232.33				
I certify under the penalty of petherein set out are true and corr paid and that the amount therei presented within 60 days of the inclusive of pulled receipts, the Claimant's Sign	rect, that no part there n is justly due me and date on which expen inless an advance was	of has heretofore been I that the same is ses were incurred	and that Claim is	there s herel	fy the above meets all pro are sufficient funds and by by approved for the above	oudget app	propriati	ons to support th	
				OUZC	a and Approved by	Pepartii	iciii 11		Date
Vendor No. (7)	Invoice # (15)	Descripti							
Fund (000)	Dept (0000)	Account (000.00-	00)		Amount		Proj	ect # (6)	
					\$ 232.33				
**************************************	************** nent:	*******	*******	****	********	*****	*****	******	*****
Cathy Saderlund, Audito	r-Controller	Ву		<u></u>			_		
				(Dept	uty Auditor)			(Date)	



RIVERSIDE MARRIOTT

GUEST FOLIO

626 ROOM NDDG TYPE	ANONYMOUS/GUEST NAME SANABRIA/SAUL XXX XXX NE	RATE	10/13/17 DEPART 10/08/17 ARRIVE	DUPLICATE TIME	14:41	769 ACCT#	7350 GROUP
ROOM	11111 ADDREGS	VSXXXXXXXXX PAYMENT	VSXXXXXXXXXXX5250 PAYMENT			MR#:	
DATE	REFERENCES	CHA	RGES	CREDITS	BA	LANCES	DUE
10/07 10/08 10/08 10/08 10/08 10/08 10/08 10/09 10/09 10/09 10/09 10/10 10/10 10/10 10/10 10/11 10/11 10/11 10/11 10/11 10/11 10/11 10/12 10/12 10/12 10/12	WFB BASEHSIA CCARD-VS VSXXXXXXXXXXX5250 CASH 754388 SLF PARK PARKING GRP GVMT 626, 1 OCC.TAX 626, 1 CAL FEE 626, 1 WFB BASEHSIA SLF PARK PARKING GRP GVMT 626, 1 OCC.TAX 626, 1 CCL FEE 626, 1 WFB BASEHSIA SLF PARK PARKING GRP GVMT 626, 1 CCL TAX 626, 1 CAL FEE 626, 1 CAL FEE 626, 1 SLF PARK PARKING GRP GVMT 626, 1 CCL TAX 626, 1 CCL TAX 626, 1 CCL TAX 626, 1 CCL FEE 626, 1 CAL FE		10.00 133.00 17.29 .40 .00 133.00 17.29 .40 .00 10.00 133.00 17.29 .40 10.00 133.00 17.29 .40 10.00 133.00 17.29	725.12			
10/12 10/13 10/13	CAL FEE 626, 1 PRK ADJ SV CCARD-VS VSXXXXXXXXXXXX5250		.40	50.00 28.33			00



RIVERSIDE MARRIOTT 3400 MARKET STREET RIVERSIDE, CA 92501 951-784-8000 FAX 951-369-7127

This statement is your only receipt. You have agreed to pay in cash or by approved personal check or to authorize us to charge your credit card for all amounts charged to you. The amounts shown in the credit card number set (orth above. (The credit card company will bill in the usual manner.) If for any reason the credit card company does not make payment on this account, you will owe us such amount. If you are direct billed, in the event payment is not made within 25 days after check-out, you will owe us interest from the check-out date on any unpaid amount at the rate of 1.5% per month (ANNUAL RATE 18%), or the maximum allowed by law, plus the reasonable cost of collection, including attorney fees.