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

COUNTY OF LAKE

TRAVEL EXPENSE CLAIM

Claimant Carrie Manning Employee No. _____

Mailing Address 4150 Scott Str, Lakeport, CA 95453 Department No. 4014

Leave Date: Nov 17, 2019 Time: 8 am Return Date: Nov 21, 2019 Time: 5 pm

Destination Las Vegas, NV

Purpose Teen Mental Health First Aid Training

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

Other/Identify $ 128.81 (Amount) 1) Airport parking (60.00) (Receipted)

2) Uber (68.81) (Receipted)

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

MEALS – PER DIEM (Travel Policy — Sec 2.1)	$ .00 (Breakfast)	(No)	$ 20.00 (Lunch)	2 (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 $ 216.81

Less Travel Advance* (.00) _____ (Date of Advance)

Total Reimbursement Due $ 216.81

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*).

Carrie Manning Claimant's Signature — Mar 9, 2020 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 — 3/20/20 Date

Vendor No. (7)	Invoice # (15)	Description (25)		
Fund (000)	Dept (0000)	Account (000.00-00)	Amount $ 216.81	Project # (6)

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Verified/Approved for Payment:

Cathy Saderlund, Auditor-Controller By _____ (Deputy Auditor) _____ (Date)

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Revised March 2012

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

COUNTY OF LAKE

TRAVEL EXPENSE CLAIM

Claimant Melissa Mathis Employee No. _____

Mailing Address 9941 Monte Cristo Drive Kelseyville CA 95451 Department No. 4014

Leave Date: 09/12/2019 Time: 12:30pm Return Date: 09/14/2019 Time: 8:30pm

Destination Metro State Hospital

Purpose Conservatorship Evaluation

TRANSPORTATION 224 (Priv Car/Air Miles) x $0. .39 (Rate) = $ 87.36 (Amount) Fares $ _____ (Public Trans)

Other/Identify $ 54.00 (Amount) 1) Parking at Sacramento Airport/Credit card stmt. (Receipted)

2) _____ (Receipted)

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

MEALS – PER DIEM (Travel Policy — Sec 2.1) $ 14.00 (Breakfast) 2 (No) $ 20.00 (Lunch) 2 (No) $ 51.00 (Dinner) 3 (No)

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

LODGING – ACTUAL (Travel Policy — Sec 4.1) $ 537.27 ✓ (Amount) 2 (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 $ 763.63

Less Travel Advance* (_____) _____ (Date of Advance)

Total Reimbursement Due $ 763.63

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*).

Claimant's Signature 3/5/2020 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 3/31/20 Date

Vendor No. (7)	Invoice # (15)	Description (25)		
Fund (000)	Dept (0000)	Account (000.00-00)	Amount $ 763.63	Project # (6)

****

Verified/Approved for Payment:

Cathy Saderlund, Auditor-Controller By _____ (Deputy Auditor) _____ (Date)