CUSTOMER MILEAGE REIMBURSEMENT SHEET

Name: _____ **OSL ID:** _____

Address: _____ **Date:** _____

Name of Training Institution and Location: _____

INSTRUCTIONS: *Below (in ink) record, by day, the actual miles traveled to CRT or other training. This sheet must be completed and returned to the Case Manager by the tenth day of the each month.* ***Failure to complete and return this form to the Case Manager will result in loss of mileage reimbursement***

Itinerary: Point of travel to and from	Date: Month and Day	Map Miles	Vicinity Miles

I certify that the miles shown are true and correct.

_____ _____

Customer signature Date

To be completed by Workforce Oklahoma Staff:				
Funding Stream: Adult ____ DLW _____ OS Youth _____ IS Youth _____ Other (list): _____				
Mileage Claimed			**Mileage Rate**	**Total Reimbursement**
Map Miles:		X		$
Vicinity Miles :		X		$
			Total Mileage Claim:	**$**

_____ _____

Case Manager Signature *Date*