early steps
Children's Medical Services

❶ Print your name and enter the address where you want the check sent.

❷ Fill in your social security number.

❸ Sign the form.

STATE OF FLORIDA
VOUCHER FOR REIMBURSEMENT
OF TRAVEL EXPENSES

TRAVELER
Address ______________________________

CHECK ONE: ____ OFFICER/EMPLOYEE ____ NONEMPLOYEE IND. CONTRACTOR ____ OPS

Social Security No. ______________________________
HEADQUARTERS ______________________________
RESIDENCE (CITY) ______________________________

DATE	Travel Performed From Point of Origin To Destination	Purpose or Reason (Name of Conference) (Purchasing Card Description)	Hour of Departure And Hour of Return	Meals for Class A & B Travel	Per Diem or Actual Lodging Expenses	Map Mileage Claimed	Vicinity Mileage Claimed	Other Expenses Amount	Other Expenses Type	PCARD Charges
			M							
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			M							

Statement of Benefits to the State: (Con...

Column Total	Column Total	0 MI. @ 44.5¢ MI.	Column Total	Summary Total
$ -	$ -	$ -	$ -	$ -

TR______ SEL____
ORG __6423 1000000
BO____ VR___ CF___ OCA______
INVOICE #____________TRAN DATE________

OBJECT	AMOUNT	OBJECT	AMOUNT
26		26	
26		26	
26		26	
26		26	

LESS ADVANCE RECEIVED ($)
LESS NON-REIMBURSABLE ITEMS INCLUDED ON PCARD ($)
NET AMOUNT DUE TRAVELER $ -
NET AMOUNT DUE THE STATE $ -

TRAVELER'S SIGNATURE: ______________________________
SIGNATURE DATE: ______________ TITLE: ______________________________

SUPERVISOR'S SIGNATURE: ______________________________
SUPERVISOR'S TITLE: ______________________________
SIGNATURE DATE: ______________________________

FOR AGENCY USE:

Preparer's Name ______________________________
Preparer's Phone No. ______________________________
Date Prepared ______________________________

Invoice no. ____________ Voucher/SWD No. ____________ RF Ck./Warrant No. ____________ RF Ck./Warrant Date ____________

DH 676 01/02