VENDOR #_____

DATE _____

SAN LUIS OBISPO COUNTY COMMUNITY COLLEGE DISTRICT

P.O. Box 8106

San Luis Obispo, California 93403-8106

CLAIM

MISCELLANEOUS

(DO NOT USE FOR TRAVEL, MILEAGE, OR CONFERENCE)

CLAIMANT_____

ADDRESS _____

_____

SSN or EMPLOYEE ID _____

DESCRIPTION	AMOUNT

If this form is used in claiming reimbursement for personal expenditures made on behalf of the district, receipted bills or sales tags verifying the expenditures must be attached.

Total $ 0.00

CERTIFICATE OF CLAIMANT:

I hereby certify that the above claim and the items, amounts and statements are true and correct; that no part has heretofore been paid; that the expenses were incurred by me while on official business for the San Luis Obispo County Community College District.

_____

Signature of Claimant

_____

Account Number

_____

Approved by Division Chair/Administrator

_____

Budget Office Approval