



\_\_\_\_\_  
 Name of Commission, Advisory Committee, Council, Task Force

**LEGISLATIVE COORDINATING COMMISSION  
 Request for Reimbursement**

This form is to be completed by legislators, public members, state employees and legislative staff and submitted, with Receipts, to the appropriate chair or director. Space is provided on the back of the form to claim meal reimbursement. The Chair/Co-Chairs or Director must return the completed form within 60 days of the legislative activity to the LCC Fiscal Services Office, G45 State Office Building. Untimely or incomplete requests will not be processed.

<u>Date</u>	<u>Description of Activity</u>	<u>Place of Meeting</u>	<u>Mileage</u>		<u>Trip Miles</u>	<u>Rnd Trip/</u>	<u>Per Diem (check)</u>	<u>Lodging</u>	<u>Other Expenses</u>
			<u>From (city)</u>	<u>To (city)</u>		<u>One Way (check)</u>			
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> RT <input type="checkbox"/> OW	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> RT <input type="checkbox"/> OW	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> RT <input type="checkbox"/> OW	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> RT <input type="checkbox"/> OW	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> RT <input type="checkbox"/> OW	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

**I declare under the penalties of perjury that this request is just and correct and that no part of it has been paid.**

\_\_\_\_\_  
 Print Member/Employee Name

\_\_\_\_\_  
 Signature of Member/Employee

\_\_\_\_\_  
 Signature of Chairperson/Director

\_\_\_\_\_  
 Signature of Co-Chair (if necessary)

**NOTE: Please attach receipts for lodging, registrations and airfare.**

For Accounting Office Use ONLY	
Member #	_____
Dept Code #	_____
Obj/Amount	_____ \$ _____
	_____ \$ _____
	_____ \$ _____
	_____ \$ _____
	_____ \$ _____
	_____ \$ _____
Total Expenses:	\$ _____

Employees may be reimbursed for actual cost of meals (up to maximum specified below). Please specify the amount of meal reimbursement you are claiming in the space provided. The following maximum meal reimbursement rates as stated in the current Legislative Plan for Employee Benefits and Policy remains in effect until amended or repealed by the LCC.

<b>Maximum In-State</b>	Breakfast - \$9.00	Lunch - \$11.00	Dinner - \$16.00
<b>Maximum Out-of-State</b>	Breakfast - \$11.00	Lunch - \$13.00	Dinner - \$20.00

Date	Breakfast	Lunch	Dinner	Total
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
<b>Total</b>	_____	_____	_____	_____

Add total to front under Other Expenses