



Volunteer Name (Please print): _____ Station: _____ County: _____

Volunteer Full Address: _____ City _____ Zip Code: _____

Please check here if your address has changed: ___ Service Month: _____ Year: _____

COMPLETED FORM DUE TO COORDINATOR BY THE 10TH OF THE FOLLOWING MONTH

Date	Total Miles	Destination/Service

Please return this form to your station supervisor by the 10th of the following month.

If your monthly mileage exceeds 150 miles, it will be subject to review and approval by program director.

Auto mileage rate is **\$.25/mile**
 Total Miles on this sheet: _____
 @ \$.25 mi = _____

**F&CS, Inc.
RSVP
Coordinator
Use Only:**
 Total # of pages _____
 Reimbursement Amount: _____
 01-90300-700-_____
 Initials: _____
 Date: _____

By signing, I certify that this statement and the amount claimed are true, correct and complete to the best of my knowledge. I certify that I possessed a valid driver's license and liability insurance in the minimum amount required by law was in force at the time of this travel. Current copies of DL & Insurance have been provided to RSVP Coordinator.

Volunteer Signature: X _____ Date: _____ Station Supervisor Signature: _____ Date: _____

RSVP Staff Signature: X _____ Date: _____ Accounts Payable Signature: _____ Date: _____