**The Autism Academy of Learning**

**Professional Day Request & Reimbursement Form**

Employee Name: _____ Date submitted: _____

Room Assigned: _____

Professional Development Function/Name of conference: _____

_____

Travel Destination (city): _____

Contact Information: Hotel Name/phone no.: _____

Work Dates Affected: From: _____ To: _____

| **Expenses** | | **Total Costs** |
|---|---|---|
| Mileage | No. of miles / mileage rate:<br>------ / --------- | $ |
| Lodging<br>($80 maximum per calendar day) | No. of nights / cost per night:<br>--- / ---------- | $ |
| Meals<br>($30 maximum per calendar day) | | $ |
| Other (specify) | | $ |
| **Total** | | $ |

***attach all receipts for lodging and meals (attach either gas receipts or mapquest directions & mileage) to this form and turn in to Office Manager for reimbursement.**

_____ _____

Employee Signature Date

□ Approved
□ Not Approved Reason: _____

_____ _____

Principal / Board President Signature Date