LICKING COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

FSS REIMBURSEMENT

Individual Name: ______________________ Date: ________

Actual Date of Occurance	**From (Location & Address)**	**To: Destination & Address (Street & City)**	**# Miles**	**Registration, Parkng or Meals Only-Attach Receipts**

Parent/Guardian Signature:	Date:	Total	**FOR OFFICE USE ONLY**
		0.00	**Total Mileage**
	Date:	$ 0.00	.50 per mile
		$ 0.00	**Total other expenses**
		$ 0.00	**Total Due**