

SCISD TRAVEL REQUEST

DATE OF REQUEST:

EMPLOYEE(S):

TRIP DATES:

ATTACH DOCUMENTATION

PURPOSE:

REGISTRATION

REGISTRATION FEE:

DEADLINE:

PAYABLE TO:

ADDRESS:

LODGING

HOTEL NAME:

HOTEL ADDRESS:

HOTEL PHONE #:

	ROOM RATE	TAX AMOUNT	TOTAL PER NIGHT	# OF ROOMS	# OF NIGHTS	PARKING	TOTAL CHECK AMOUNT
CITY TAX RATE %:							

MEALS

Each employee will be reimbursed on a per-diem basis.

***Per-diem is based on time of departure and return.*

Departure Time:

Return Time:

Per Person	Number	Amount	
Breakfast: \$8.00			
Lunch: \$12.00			
Dinner: \$16.00			
TOTAL MEAL COSTS:			

APPROVAL

Requesting Party:

DATE:

Principal/Director:

DATE:

BUDGET CODES:

AMOUNT:

AMOUNT:

AMOUNT:

Business Manager:

Superintendent: