

PAYROLL CLERK USE ONLY	
PAID PPE:	_____
INITIAL:	_____

**COUNTY OF SONOMA
PERSONAL AUTOMOBILE MILEAGE CLAIM**

DEPARTMENT: _____

EMPLOYEE: _____

EMPLOYEE ID #: _____

DATE	DESCRIPTION: (PASSENGER NAME(S), PURPOSE & DESTINATION)	MILES DRIVEN

Mileage Rate Effective 1/1/2024

TOTAL MILES DRIVEN:

MILEAGE RATE:

TOTAL REIMBURSEMENT:

I certify that the mileage claimed was actual and for official business of the Department, and that I have a valid driver's license and adequate insurance to meet County requirements. I am requesting reimbursement as an employee and acknowledge that this reimbursement will be processed through the County's Payroll System and must be submitted for payment no later than 90 days following the date of travel.

_____ Date

_____ Employee Signature

_____ Date

_____ Authorized Approval