

TR# _____
 VENDOR # _____
 PAYEE NAME: _____
 TRAVELER'S NAME: _____
 SSN OR EMPLOYEE ID#: _____
 DATE: _____

TRAVEL REIMBURSEMENT VOUCHER

Medical University of South Carolina

I do solemnly swear/affirm that the below account is just and true in all aspects and that the expense shown herein was incurred on official business for the State of South Carolina.

Signature of traveler: _____

| Date Mo/Da | Dep Arr | Time | Am Pm | Destination of travel departure Departure Destination Return | POV Miles | POV Amt | Meals | Lodging | Air Trans | Other Trans | Misc. Travel Exp | Registration Fees |
|---------------|------------|------|----------|-----------------------------------------------------------------------|--------------|------------|-------|---------|--------------|----------------|------------------------|----------------------|
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Totals

Purpose of Trip:

Authorized Signature:

Payee Address:

If traveler, must use home address (Please send check to)
 Name: _____
 Location: _____

| Alias | Entity | Account | Unit | Project | RPTG | Year | Amt |
|-------|--------|---------|------|---------|------|------|-----|
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TOTAL: _____

Vendor # to be completed by Travel Office
 User Code to be completed by Accounts Payable
 Revised 2-2011

NOTE: THIS FORM MUST HAVE A VALID NUMBER ISSUED BY UNIVERSITY PRESS TO BE PROCESSED