TRAVEL PRE-AUTHORIZATION FORM

NAME OF OFFICER:	
POSITION/UNIT/ORGANIZATION:	

CONDITIONS OF TRAVEL:

1. Authorization must be sought on this form **prior to travel.**
2. Mileage claims **must be submitted within 30 days** after completion of travel, in order to be reimbursable.

ITINERARY AND DATES				
DATE/TIME:	FROM:	TO:	ESTIMATED TRAVEL DISTANCE (KM) [IF BY PERSONAL MOTOR VEHICLE, STATE SHORTEST DRIVING DISTANCE BETWEEN LOCATIONS]	REASON FOR TRAVEL

Officer Name: _____ Supervisor Name: _____

Officer Signature:_____ Supervisor Signature:_____

Date: _____ Date: _____