

TR# _____
 VENDOR # _____
 PAYEE NAME: _____
 TRAVELER'S NAME: _____
 SSN: _____
 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

Totals							
Alias	Entity	Account	Unit	Project	RPTG	Year	Amt

Purpose of Trip:

Authorized Signature:

Payee Address:

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

TOTAL: _____

Vendor # to be completed by Travel Office
 User Code to be completed by Accounts Payable
 UP No. 411155 Rev. 9/97

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