

**COLLEGE OF OSTEOPATHIC MEDICINE
PRE-TRAVEL AUTHORIZATION FORM**

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|--------------|----------------------|
| NAME: | DATE OF DEPARTURE: |
| | DATE OF RETURN: |
| DEPARTMENT: | ACCT# To be Charged: |
| | ACCT Title: |
| DESTINATION: | PURPOSE OF TRAVEL: |

List all projected expenditures to be charged to the Travel account:

| DESCRIPTION | AMOUNT |
|--|--------|
| 1. Per Diem: days @ \$35.00/day: | |
| 2. Mileage: miles @ \$.505 | |
| 3. Parking: days @ \$ | |
| 4. Gratuities (bellhops, shuttles, taxis): (Estimation) | |
| 5. Car Rental: | |
| 6. Taxi: | |
| 7. Registration Fees: | |
| 8. Hotel: #Nights @ /Night (with tax) : | |
| 9. Other: | |

Total : _____

Number of days of meeting attendance: _____

Number of days requested of other (e.g., vacation): _____

Explanation of "other": _____

Signature (Traveler)

Authorization:

Signature (Budget Manager/Supervisor)