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| logo_forms | | Wisconsin Department of Public Instruction  **CLAIM FOR REIMBURSEMENT**  PI-1135 (Rev. 08-15)  *Collection of this information is a requirement of section 16.525(7)(b), Wis. Stats.* | | | | | | | | | | | | | | | **INSTRUCTIONS:** Complete and sign one copy. Attach original receipts and submit to:  **WISCONSIN DEPARTMENT OF PUBLIC INSTRUCTION**  **BUSINESS OFFICE**  **PO BOX 7841**  **MADISON, WI 53707-7841** | | | | | | | | | | | |
| **DPI Coordinator:** Submit all reimbursement claims for this event with a copy of the agenda, if appropriate, to the Business Office. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of Conference/Meeting  WI Health Award Ceremony | | | | | | | | | | | | DPI Coordinator for Conference/Meeting  Brenda Jennings | | | | | | | | | | | | | | | |
| Location of Conference/Meeting  Radisson Paper Valley | | | | | | | | | | | | Attendance Date(s)  December 7, 2017 | | | | | | | | | | | | | | | |
| Claimant or Coordinator | | | | | | | | | | | | Social Security or Tax ID No.\* | | | | | | | | | | | Business Telephone *Area/No.* | | | | |
| Mailing Address *Street, City, State, Zip* | | | | | | | | | | | | | | | | | | | | | | | Purchase Order No. | | | | |
|  | | | | | | | | | I. EXPENSES | | | | | | | | | | |  | | | | | | | |
| *Complete only if meal or lodging expense claimed.* | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Departure Time from Home Base *Date and Time of Day* | | | | | | | | | | | | | | 2. Time of Return to Home Base *Date and Time of Day* | | | | | | | | | | | | | |
| **A. AUTOMOBILE EXPENDITURES** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Starting Point *City* | | | | 2. Destination *City* | | | | | | | 3. Total Miles Driven *Round Trip* | | | | | | | | 4. Reimburse Rate  *.51¢ / mile* | | | | | 5. TOTAL Auto Expenditures *Col. 3 x Col. 4*  $0.00  $0.00 | | | |
| **B. OTHER TRANSPORTATION** *(Air, Bus, Train, Taxi)* **EXPENDITURES** *Attach Original Receipts* | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Type(s) of Transportation | | | | | | | | | | | | | | | | | | | | | | | | 2. TOTAL Other Trans. Expenditures | | | |
| **C. LODGING EXPENDITURES** *Attach Original Receipts* | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| In-State Max.\* $82 + tax for most cities: *See Below*  Out-of-State Max. depends on city *Refer to state guidelines.* | | | | | | City | | | | | | | | | | | | Rate | | | No. of Nights | | | | 3. TOTAL Lodging Expenditures  $0.00  $0.00 | | |
| **D. MEAL EXPENDITURES** *Claims should be made for* ***actual*** *costs incurred and are not to exceed state limits.* | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Breakfast *Allowable when departing prior to 6 a.m. Maximum In-state = $8 inc. tip* | | | | | 2. Lunch *Allowable when departing prior to 10:30 a.m. and returning after 2:30 p.m. Maximum In-state = $10 inc. tip* | | | | | | | | | | | | 3. Dinner *Allowable when returning after 7 p.m. Maximum In-state = $20 inc. tip* | | | | | | | | | | 4. TOTAL Meal Expenditures *Col. 1 + 2 + 3* |
| No. of Breakfasts | | Total Amt. | | | No. of Lunches | | | | | Total Amt. | | | | | | | No. of Dinners | | | | | Total Amt. | | | | | $0.00 |
| **E. PER DIEM/STIPEND/MISCELLANEOUS** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *If Per Diem Claimed* | | | | | | | | | | | | | *If Stipend Claimed/Misc.* | | | | | | | | | | | | | | |
| 1. No. of Days | | | 2. Rate per Day | | | | | | | | | | 3. Amount of Stipend/Misc. | | | | | | | | | | | | | 1. TOTAL   $0$0 | |
|  | | | | | | | | | II. FEE OR HONORARIUM | | | | | | | | | | |  | | | | | | | |
| *If Daily Rate Charged* | | | | | | | | | | | | | *If Flat Fee or Honorarium* | | | | | | | | | | | | | 4. TOTAL | |
| 1. No. of Days | | | 2. Rate per Day | | | | | | | | | | 3. Amount of Fee or Honorarium | | | | | | | | | | | | | $0 | |
| Signature of Claimant  ⮚ | | | | | | | Date Submitted | | | | | | **TOTAL CLAIM**  *Section I (items A, B, C, D, & E) plus Section II* | | | | | | | | | | | | | $0.00 | |
| ***FOR DPI USE*** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Signature of Conference/Mtg. Coordinator  ⮚ | | | | | | | | Date Signed *Mo./Day/Yr.* | | | | | | | Signature of Contracted Services Coordinator  ⮚ | | | | | | | | | | | Date Signed Mo./Day/Yr. | |
| Signature of Program Administrator  ⮚ | | | | | | | | Date Signed *Mo./Day/Yr.* | | | | | | | *For Business Office Use* Program/Project Name and Account Code | | | | | | | | | | | | |

\*Milwaukee, Racine, and Waukesha counties—Maximum is $90

\* Collection of Social Security Number is for processing use only and will not be shared without permission.