

STATE OF NORTH CAROLINA
Judicial Branch Of Government

**REIMBURSEMENT OF TRAVEL AND
OTHER EXPENSES INCURRED IN THE
DISCHARGE OF OFFICIAL BUSINESS**

G.S. 138-6

INSTRUCTIONS: Prepare two typewritten copies. Forward the original copy of this form and all necessary receipts/supporting document (hotel, registration, parking, airline, rail, bus, out-of-state authorization) to the Administrative Office of the Courts, Attn: Financial Services Division, Courier Box 56-10-50, Raleigh, NC, OR if courier is not available, mail to P. O. Box 2448, Raleigh, NC 27602. Retain copy for your records.

<input type="checkbox"/> Directors Office	<input type="checkbox"/> Warehouse	<input type="checkbox"/> Supreme Court	<input type="checkbox"/> Public Defender's Office	<input type="checkbox"/> DA's Conf.	<input type="checkbox"/> Office Ind. Def.
<input type="checkbox"/> Sr. Deputy Director	<input type="checkbox"/> Print Shop	<input type="checkbox"/> Court Of Appeals	<input type="checkbox"/> Special Counsel's Office	<input type="checkbox"/> Guardian ad Litem	
<input type="checkbox"/> Human Resources	<input type="checkbox"/> Court Svcs	<input type="checkbox"/> Superior Court	<input type="checkbox"/> Appellate Def's Sers.	<input type="checkbox"/> Sentencing Services	
<input type="checkbox"/> Financial Services	<input type="checkbox"/> Technology Svcs	<input type="checkbox"/> District Court	<input type="checkbox"/> Judicial Standards Comm.	<input type="checkbox"/> Sentencing Comm.	
<input type="checkbox"/> Purchasing	<input type="checkbox"/> Legal Svcs	<input type="checkbox"/> CSC's Office	<input type="checkbox"/> District Attorney's Office	<input type="checkbox"/> Dispute Res. Comm.	

Payee's Name And Address Check If Name Or Address Change		Title	Headquarters (City)
Social Security No. (Last 4 Digits)		Travel For (Month And Year)	Date Request Prepared

Under penalties of perjury, I certify this is a true and accurate statement of the city of lodging, expenses, and allowances incurred in the service of the state. <i>(Signature Of Claimant)</i>	I have examined this reimbursement request and certify that it is just and reasonable. <i>(Signature Of Supervisor)</i>	Total Cost	
		Less Advance	
		Reimbursement	

FOR USE BY AOC FINANCIAL SERVICES DIVISION

COMPANY	ACCOUNT	CENTER	AMOUNT	Date
	532714			
	532721			
	532724			
				Verified And Approved For Payment:

Day	TRAVEL (Show Each City Visited)		TRANSPORTATION			SUBSISTENCE			OTHER EXPENSES	
	From	To	(1) Mode	Daily Private Car Mileage	Amount	(2) Type	In-State	Out-of-State	Explanation	Amount
			P			B				
			A			L				
	Purpose of Trip:		B			D				
	Depart Time	Return Time	R			H				
			P			Total				
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	Purpose of Trip:		B			D				
	Depart Time	Return Time	R			H				
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	Purpose of Trip:		B			D				
	Depart Time	Return Time	R			H				
			P			Total				

(1) Mode of Travel:	(2) Type of Subsistence:	In-State	Out-of-State	Total Trans.	Total Auth. Sub.	Total Auth. Sub.	Total Other Exp.
P-Pr-owned car	Breakfast	\$ 7.50	\$ 7.50				
A-Air	Lunch	9.75	9.75				
B-Bus	Dinner	16.75	19.00				
R-Rail	Room	63.75 + tax	75.50 + tax				
	24-hr. period	\$ 97.75	\$ 111.75				

Check List: (1) Claimant and supervisor signature (2) Depart and return times required to claim meals (3) Must have itemized hotel receipt - credit card receipt not accepted.

NOTE: Purpose of trip must be noted, please indicate purpose of trip under city visited.

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TOTALS BROUGHT FORWARD										
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