CLEAR FORM

PRINT

FULTON COUNTY EXPENSE VOUCHER

*** ATTACH ALL RECEIPTS. Expenses (other than mileage) submitted without receipts will not be reimbursed.**

Name of Reimbursee:

(First-Middle Initial-Last Name)

If travel, names of others in vehicle:

Job Title & Department:

Purpose:

Where expenditure(s) will be paid from:

Line Item Account #	**Amount**

Health Department Program Code:

IRS mileage rate as of January 1, 2026 is $.725 cents per mile

Date	**Origin**	**Destination**	**Total Miles**	**Amount Due** @ .725	**Lodging**	**Meals**	**Other Expenses** Item	Amount	**Line Total**
		Sub Totals							
								Total Amount	
								Total Reimbursement Requested	

This certifies that the travel shown above was required by the official duties of the traveler named.

I certify that the above amount is correct and just; that the detailed items charged within are actual expenses I incurred while conducting official Fulton County business, that the amounts reported were actually paid by me, and the expenses were occasioned by official business or unavoidable delays requiring expenditure of personal funds that I am now requesting reimbursement for; and that I expended the necessary funds in an ethical and prudent manner.

Reimbursee Signature *Date*

Department Head (or Chair) signature: *Date*

last updated 1/5/2026