

TRAVEL VOUCHER

THOSE AREAS THAT ARE SHADED MUST BE COMPLETED BY THE TRAVELER

1 Originating Agency SUNY Optometry		Orig. Agency Code 28580		Interest Eligible (Y/N) N	
Payment Date (MM/DD/YY)		OSC Use Only		Liability Date (MM/DD/YY)	
2 Payee ID	Additional	Zip Code	Route	Payee Amount	MIR Date (MM/DD/YY)
3 Payee Name (Last)	(FI)	(MI)	(Suffix)	IRS Code	IRS Amount
4 Address (to mail check to)			Stat Type	Statistic	Indicator-Dept. Indicator-Statewide
City		State	Zip	Ref/Inv. # (limit 14 additional spaces)	Ref/Inv.Date mm/dd/yy
5 Purpose of Travel (be specific):			6 Official Station		
7 Destination (include county):			8 Residence (if different than #4)		
9 Date & Time of Departure AM PM	10 Date & Time of Return AM PM	Neg. Unit	Travel Advance (Yes/No)	Corporate Card Used (Yes/No)	
11 Regular Work Hours:			12 Mode of Transportation/Ticket #, Rental Agreement #:		

Section 1 - Indicate All Travel Expenses - Use detail sheet if necessary				Section 2 - Summary	
				TOTALS	Amount
13 Lodging					A. Total travel expenses \$0.00
14 Transportation Expense					B. Subtract amount billed directly to agency-corp card
15 Miscellaneous Expenses/Explanations					C. Subtract amount paid with Travel Advance
16 Per Diem Allowance	Days at \$	per day = \$	0	\$0.00	D. Other adjustments (specify)
	Days at \$	per day = \$	0	\$0.00	
17 Meals Only	Breakfasts at \$	+ Dinners at \$	\$0.00	\$0.00	
	Breakfasts at \$	+ Dinners at \$	\$0.00	\$0.00	
18 Total Mileage from attached AC 16C	miles at	cents per mile		\$0.00	Total amount to be reimbursed to traveler/ (or if negative) total amount to be returned to agency (attach check)
Total Travel Expenses				\$0.00	\$0.00
Enter in Section 2 Line A					

PAYEE'S CERTIFICATION		STATE COMPTROLLER'S PRE AUDIT	
I hereby certify that the above account and schedules are just, true, and correct; that no part thereof has been paid, except as stated therein, and that the balance therein stated is actually due and owing, and that the amounts claimed were necessary and incurred in the performance of my authorized official duties.		Certified for payment by	
Signature: _____ Date: _____ e-mail: _____ Work Phone: _____		For Agency Finance Office Use Only	
SUPERVISOR'S CERTIFICATION		I certify that this claim is correct and just and that this payment is approved	
I, the claimant's supervisor, certify this account has been examined and, to the best of my knowledge and belief, the amounts claimed were necessary for the performance of the claimant's authorized official duties.		By: _____	
Supervisor's Signature: _____ Date: _____		Authorized Signature	
Name & Title (Print/Type Legibly):		Title: _____	
		Date: _____	

EXPENDITURE						
Dept.	Cost Center	Variable	Year	Object Code	Amount	TR Fiscal Control #

