CLAIM FOR REIMBURSEMENT
FOR EXPENDITURES
ON OFFICIAL BUSINESS

Read the Privacy Act Statement on the back of this form.

4. CLAIMANT
   a. NAME (Last, first, middle initial)
   b. SOCIAL SECURITY NUMBER
   c. MAILING ADDRESS (Include ZIP Code)
   d. OFFICE TELEPHONE NUMBER

5. PAID BY

6. EXPENDITURES (If fare or toll claimed in column (g) exceeds charge for one person, show in column (h) the number of additional persons which accompanied the claimant.)

   DATE
   CODE
   A - Local Travel
   B - Telephone or Telegraph
   C - Other expenses (itemized)
   D. Funeral Honors Detail
   E. Specialty Care
   (Explain expenditures in specific detail)
   MILEAGE RATE
   (Enter Whole Numbers Only)
   AMOUNT CLAIMED
   NUMBER OF MILES
   (a)
   FARE
   OR TOLL
   (g)
   ADDITIONAL
   PERSONS
   (h)
   TIPS AND
   MISCELLANEOUS
   (j)

    (a) FROM
    (b)
    (c) TO

If additional space is required continue on the back.

SUBTOTALS CARRIED FORWARD FROM THE BACK

7. AMOUNT CLAIMED (Total of columns (f), (g) and (i)) $

8. This claim is approved. Long distance telephone calls, if shown, are certified as necessary in the interest of the Government. (Note: If long distance calls are included, the approving official must have been authorized in writing, by the head of the department or agency so certify (31 U.S.C. 650a).)

9. This claim is certified correct and proper for payment.
   AUTHORIZED
   CERTIFYING OFFICER
   SIGN HERE

10. I certify that this claim is true and correct to the best of my knowledge and belief and that payment or credit has not been received by me.
   Sign Original Only

   CLAIMANT SIGN HERE DATE

11. CASH PAYMENT RECEIPT
   a. PAYEE (Signature)
   b. DATE RECEIVED
   c. AMOUNT

   PAYMENT MADE
   BY CHECK NUMBER

   ACCOUNTING CLASSIFICATION
   Functional Area:
   Cost Center:
   Fund:
   WBS:

OPTIONAL FORM 1164 (REV. 12/2016)