

State of New York Travel Voucher

Voucher Number

Originating Agency			Agency Code		Interest Eligible Y/N N		Voucher Number	
Payment Date MM/DD/YY / /			OSC Use Only			Liability Date MM/DD/YY / /		
Payee ID		Additional	Zip Code		Route	Payee Amount		MIR Date MM/DD/YY / /
Payee Name (Last)			FI	MI	Suffix	IRS Code	IRS Amount	
Address					Stat Type	Statistic	Indicator Dept	Ind Statewide
Address					Ref/Inv Number (14 additional spaces) TRAVEL			
City		State	Zip		Ref/Inv Date MM/DD/YY / /			
Purpose of Travel					Official Station			
Destination (including county)					Residence			

Departure Date And Time		Return Date And Time		Neg Unit	Travel Advance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Paid By Direct Bill	<input type="checkbox"/> Yes <input type="checkbox"/> No	Corporate Card Used	<input type="checkbox"/> Yes <input type="checkbox"/> No
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1) Indicate All Travel Expenses – Use detail sheet if necessary	Totals	2) Summary	Amount
Lodging		A. Total Travel Expenses	
		B. Subtract Amount Billed Directly to Agency (Amex)	
Transportation		Other Direct Bill to Agency (Specify)	
		C. Subtract Amount Paid With Travel Advance	
Meals		D. Other Adjustments (Specify)	
Mileage @ ¢ per mile =			
Incidental Expenses (List)			
Total Travel Expenses - Enter in Section 2 Line A		Total Amount To Be Reimbursed To Traveler	

Payee's Certification			State Comptroller's Pre-Audit Certified For Payment By		
I hereby certify that the above account and attached 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 official duties.			_____		
Signature _____ Title _____ Date _____			Agency Finance Office Use		
Supervisor's Certification			I certify that this claim is correct and just, and that this payment is approved		
I, the claimant's supervisor, certify that this account has been examined and to the best of my knowledge and belief, the amounts claimed therein were necessary for the performance of the claimant's authorized official duties.			_____		
Signature of Supervisor _____ Title _____ Date _____			Authorized Signature _____		
Signature of Supervisor _____ Title _____ Date _____			Title _____ Date _____		

Expenditure							Liquidation				
Cost Center Code				Object	Accum		Amount	Orig. Agency	PO/Contract	Line	F/P
Dept.	Cost Center Unit	Var	Yr		Dept.	Statewide					
							⋮				
							⋮				
							⋮				
							⋮				
							⋮				