Romoland School District
Mileage Expense Reimbursement

MONTH of: _____ **PR/PO #:** _____

EMPLOYEE'S NAME: _____ **SCHOOL/DEPT.:** _____

DATE	FROM	TO	MILES	PURPOSE

Total Miles _____ **x** **.725¢ per mile** **=** **$** _____

2026 Rate

I certify the mileage listed was necessary to perform my duties as assigned and that I currently have the minimum automobile liability, bodily injury, and property insurance coverage required by California law.

_____ _____

Signature of Employee Signature of Principal or Department Head

_____ _____

Title of Employee District Office Approval