COUNTY OF LOS ANGELES
EXPENSE CLAIM

DEPARTMENT OF MENTAL HEALTH ______________________

TO ______________________ HEADQUARTERS ______________________

ADDRESS ______________________ DATE OF CLAIM ______________________

______________________ PERIOD OF CLAIM ______________________

SHOW PURPOSE OF TRIP ITEMIZE IN DETAIL

DATE	DESCRIPTION OF EXPENSE	PLACE WHERE INCURRED	AMOUNT	
		TOTAL CLAIMED		

I HEREBY CERTIFY THAT THE ABOVE EXPENSE WAS NECESSARILY INCURRED IN THE PERFORMANCE OF MY DUTY.

AS ______________________

CLAIM IS HEREBY MADE FOR REIMBURSEMENT AS ITEMIZED ABOVE.

____

SIGNED Claimant

APPROVED

____

____

TITLE

76E928 - Cdb 9-68