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.

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SIGNED Claimant

APPROVED

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TITLE

76E928 - Cdb 9-68