



DISTRICT 2 PUBLIC HEALTH 2026 LODGING REQUEST

Employee: _____ Today's Date: _____
 Employee's Home Base: _____
 Name of Training: _____
 Location of Training: _____ Budget Reimbursing Lodging: _____
 Lodging Dates: _____

APPROXIMATE EXPENSE:

<u>Expense</u>	<u>Quantity</u>	<u>Cost</u>
Meals	_____	\$ _____
Lodging	_____	\$ _____
Mileage	_____	\$ _____
Carrier (round trip)	_____	\$ _____
Other	_____	\$ _____
APPROXIMATE TOTAL COST:		\$ _____

Employee's signature: _____ Supervisor's signature: _____

Approved by DPH: Yes _____ N/A _____ If Yes, State Approval Confirmation attached: Yes _____ No _____

Approved: Yes _____ No _____

 Program Manager Date

Approved: Yes _____ No _____

 Financial Administrator Date

Approved: Yes _____ No _____

 District Health Director Date

If not approved, please state reason:

