AC 132-A (Rev. 11/04)

State of New York Travel Voucher

Voucher Number			
Originating Agency	Agency Code	Interest Eligible Y/N **N**	
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)	SPACE	FI	SPACE
MI	SPACE	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 ☐ Yes ☐ No	Paid By Direct Bill ☐ Yes ☐ No	Corporate Card ☐ Yes ☐ No

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 (Corporate Card)	
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		**Total Amount To Be Reimbursed To Traveler**	

Payee's Certification

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.

_____

Supervisor's Certification

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

State Comptroller's Pre-Audit Certified For Payment By

_____

Agency Finance Office Use

I certify that this claim is correct and just, and that this payment is approved

_____

Authorized Signature

_____

Title Date

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