



**STATE OF MARYLAND
EXPENSE ACCOUNT**

GAD FORM X5
FID 526002033

Accounts Payable Use Only

Employee ID	LOCATION	000
DEPT/PROJ(1)	ACCT(1)	
PROGRAM(1)	FUND(1)	
AMOUNT(1)		
DEPT/PROJ(1)	ACCT(1)	
PROGRAM(2)	FUND(2)	
AMOUNT(2)		
INVOICE#		
INVOICE DATE		
SERVICE DATE		
PAYMENT TERMS	NET 7	SHC
PAYMENT MESSAGE		
QUANTITY, QUALITY, PRICES-EXTENSIONS OK		
APPROVED BY		

DEPARTMENT: UNIVERSITY SYSTEM OF MARYLAND
 UNIT OF DIVISION: FROSTBURG STATE UNIVERSITY R26
 EMPLOYEE NAME: _____
 HOME ADDRESS: _____

City: _____ State: _____ Zip: _____
 Empl ID: _____ OFFICE PHONE: _____
 Dept/Proj: _____ Acct: _____ Pgm: _____ Fund: _____ Amt: _____
 Dept/Proj: _____ Acct: _____ Pgm: _____ Fund: _____ Amt: _____

REQUEST FORM SUBMITTED: YES NO ADVANCE RECEIVED: YES NO
(REQUEST FORMS ARE REQUIRED FOR ALL OUT-OF-STATE AND FOREIGN TRAVEL) TRAVEL CARD USED: YES NO

For Period Beginning: _____ Ending _____

Include both reimbursable and University Diners Club Travel Card expenses in the matrix below:

DATE	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	TOTALS
Hotel Room								-
Breakfast								-
Lunch								-
Dinner								-
Telephone								-
Fare (indicate below)								-
Taxi and/or Shuttles								-
Bridge or Road Tolls								-
Mileage*(see below)								-
Parking								-
Registration Fee								-
								-
								-
Totals	-	-	-	-	-	-	-	-

Do not include State Procurement card charges in above matrix, but attach copies of receipts LESS: ADVANCES/TRAVEL CARD CHARGES _____
 PROCARD receipt copies attached: Hotel Registration Other: _____ NET DUE TO/(FROM) EMPLOYEE _____

Method of Travel: Plane Train Bus State Vehicle Private Vehicle - State Car Available Private Vehicle - State Car Not Available Other: _____
 Purpose of Travel: _____

Date	Time		TERRITORY COVERED INCURRING ABOVE EXPENSES	Total Number of Miles Traveled	Less: Normal Commute Miles	*Reimbursable Miles
	Start	End				
Sunday						-
Monday						-
Tuesday						-
Wednesday						-
Thursday						-
Friday						-
Saturday						-

Approved by: _____ Date: _____ Secondary Signature (if required): _____ Date: _____
Department/Project Manager Date Secondary Signature (if required) Date

Certified just and correct and payment not received
 Signature of Employee: _____ Date: _____