



Kansas Legislative Intern Program Intern Mileage Reimbursement Form

Please print legibly; incomplete forms will NOT be processed.

Name:

(Last)

(First)

Social Security Number (required for State issued payment):

University/School:

Legislator for whom you interned:

Legislator Signature:

Amount eligible for reimbursement (\$600 max per legislator):

School Address (address from which you drove while interning):

Street

City Zip

Phone #

Permanent Mailing Address (address after 5/15 to which reimbursement check will be mailed):

Street

City Zip

Phone # (if different from school phone)

INTERNAL USE ONLY - TO BE COMPLETED BY KANSAS INTERN PROGRAM COORDINATOR

Intern Program Evaluation: ___ Complete Date: _____

Legislator Program Evaluation: ___ Complete Date: _____

Policy Proposal Project: ___ Complete Date: _____

Days Eligible for Reimbursement (Attendance Log): _____ Coordinator Initial: _____