

# How to Submit a Travel Expense Claim

**When should I submit a Travel Expense Claim (TEC)?** To ensure timely processing, please submit a monthly claim between the 1st and 10th of the month after the month you are claiming expenses for (ex. Submit an October TEC between November 1st-10th).

Clear
Print
Important Note

STATE OF CALIFORNIA - DEPARTMENT OF PERSONNEL ADMINISTRATION  
**TRAVEL EXPENSE CLAIM**  
 STD. 262 (REV. 9/2007)

*See Instructions and "Privacy Statement On Reverse Side"*

Page \_\_\_\_\_ of \_\_\_\_\_ Pages

CLAIMANT'S NAME John Smith		SSN or EMPLOYEE NUMBER* 123-45-678		DEPARTMENT CA Health Corps	
POSITION Registered Nurse		CB/ID No.	DIVISION or BUREAU EMSA		INDEX NUMBER
RESIDENCE ADDRESS * 1234 Apple St			HEADQUARTERS ADDRESS 10901 Goldcenter Dr. Suite 400		TELEPHONE NUMBER (916) 322-4336
CITY Sacramento	STATE CA	ZIP CODE 95818	CITY Rancho Cordova		STATE CA ZIP CODE 95670
(1) NORMAL WORK HOURS 0700-1900			(2) PRIVATE VEHICLE LICENSE NUMBER AB123CD		(3) MILEAGE RATE CLAIMED 0.560

(5) DATE	(5) TIME	(6) LOCATION WHERE EXPENSES WERE INCURRED	(7) LODGING	(8) MEALS			(9) INCIDENTALS	(10) TRANSPORTATION				(11) BUSINESS EXPENSE	(12) TOTAL EXPENSES FOR DAY		
				BREAK-FAST	LUNCH	O.T., L.T., N.C. RELO. OR DINNER		(A) COST OF TRANS.	(B) TYPE USED	(C) CARFARE, TOLLS, PARKING	(D) PRIVATE CAR USE				
										MILES	AMOUNT				
1	1400	Sacramento to Redding									165.00	92.40		92.40	
2		Redding		6.87	9.56	21.11						0.00		37.54	
3		Redding		4.93	10.14	17.89						0.00		32.96	
4		Redding		6.09	8.54	22.30						0.00		36.93	
5		Redding		5.47	10.62	14.43						0.00		30.52	
6	0900	Redding to Sacramento									165.00	92.40		92.40	
												0.00		0.00	
												0.00		0.00	
												0.00		0.00	
												0.00		0.00	
												0.00		0.00	
												0.00		0.00	
<b>(13) SUBTOTALS</b>			0.00	23.36	38.86	75.73	0.00	0.00			0.00	330.00	184.80	0.00	322.75
<b>COLUMN CODE (ACCTG. USE ONLY)</b>															
<b>CLAIM TOTAL</b>														\$322.75	

(14) PURPOSE OF TRIP, REMARKS AND DETAILS (Attach receipts/vouchers when required)  
 (916)555-8937

AGENCY ACCOUNTING OFFICE USE ONLY	
PAID BY REVOLVING FUND CHECK NUMBER	

(15) I HEREBY CERTIFY That the above is a true statement of the travel expenses incurred by me in accordance with DPA rules in the service of the State of California. If a privately owned vehicle was used, and if mileage rates exceed the minimum rate, I certify that the cost of operating the vehicle was equal to or greater than the rate claimed, and that I have met the requirements as prescribed by SAM Sections 0750, 0751, 0752, 0753 and 0754 pertaining to vehicle safety and seat belt usage.

CLAIMANT'S SIGNATURE 	DATE 06/19/20	(16) SIGNATURE OF OFFICER APPROVING TRAVEL AND PAYMENT 	DATE
(17) SPECIAL EXPENSE AUTHORIZATION - SIGNATURE AND TITLE (See Item 17 on reverse)		DATE	

1. Go to **Your CA Health Corps Portal**.
2. Go to the **Resources** tab in the menu bar.
3. Click on **“Travel Expense Claim - STD 262”**
4. Download or print the PDF.
  - a. Note: The PDF is fillable, so you can fill in the fields directly from your computer once you download it.
5. Enter your **name, position, address, city, state, zip code**, and Social Security Number (**SSN**) (Health Corps participants do not have a designated employee number).
  - a. Enter “CA Health Corps” for Department, “EMSA” for Division.
  - b. Headquarters Address:

**10901 Gold Center Drive, Suite 400  
Rancho Cordova, CA 95670**

*Note: Index Number and Telephone Number are not required.*

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RESIDENCE ADDRESS * 1234 Apple St			HEADQUARTERS ADDRESS 10901 Goldcenter Dr. Suite 400			TELEPHONE NUMBER (916) 322-4336
CITY Sacramento	STATE CA	ZIP CODE 95818	CITY Rancho Cordova		STATE CA	ZIP CODE 95670

6. Enter your **normal work hours** in military time (ie: 8:00am = 0800, 2:00pm = 1400), your **license plate number**, and the **mileage rate claimed** (0.56).

(1) NORMAL WORK HOURS 0700-1900			(2) PRIVATE VEHICLE LICENSE NUMBER AB123CD			(3) MILEAGE RATE CLAIMED 0.560		
(4) MONTH/YEAR	(7)	(8)	(9)	(10)	TRANSPORTATION	(11)	(12)	

7. Enter the month/ year of your deployment date (ie: 10/20).

(4) MONTH/YEAR 06/2020
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8. Enter the date of the expense, the time your deployment began and ended, where the expense incurred, and enter expenses in their appropriate column.

- a. Please input expenses from one day on one row if the expenses incurred in the same general location. For example, if you bought breakfast, lunch, and dinner in Redding, California, please input each expense on the same row (see example on page 1).

(4) MONTH/YEAR	(5) DATE	(5) TIME	(6) LOCATION WHERE EXPENSES WERE INCURRED	(7) LODGING	(8) MEALS			(9) INCIDENTALS	(10) TRANSPORTATION				(11) BUSINESS EXPENSE	(12) TOTAL EXPENSES FOR DAY
					BREAK-FAST	LUNCH	O.T., L.T. N/C, RELO. OR DINNER		(A) COST OF TRANS.	(B) TYPE USED	(C) CARFARE, TOLLS, PARKING	(D) PRIVATE CAR USE		
										MILES	AMOUNT			
	1	1400	Sacramento to Redding								165.00	94.88		94.88
	2		Redding		6.87	9.56	21.11					0.00		37.54

10. In section 14, write your phone number, and any explanations of incidental costs, tolls or parking, and an explanation of lodging costs if you had to pay out of pocket.


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(14) PURPOSE OF TRIP, REMARKS AND DETAILS (Attach receipts/vouchers when required)

(916)555-8937

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11. Include your wet signature and the date.

CLAIMANT'S SIGNATURE 	DATE 06/19/20
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12. Attach your receipts to the end of the document.
13. Send your completed Travel Expense Claim to [cahealthcorps@ems.ca.gov](mailto:cahealthcorps@ems.ca.gov) with the subject line “[Month] Travel Expense Claim [secure]” or mail it to the following address:

**Emergency Medical Services Authority  
10901 Gold Center Drive, Suite 400  
Rancho Cordova, CA 95670  
Attention: Travel Coordinator**

***If you have additional questions you can email the CA Health Corps team at [cahealthcorps@ems.ca.gov](mailto:cahealthcorps@ems.ca.gov).***