# Travel [AGENCY] [MONTH] [YEAR]

Organization Name

Address, City, State Zip

Telephone number

Fax Number

Contract Number: **XXXXXXXXXX**

Contract Period: 10/1/2018-9/30/2021

Total Contract Amount: **$XXX,XXX**

For the month of MONTH YEAR

|  |  |
| --- | --- |
| Budget Line Item | Current Month Amount |
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**Note:**

* **Trip maximum 99 miles**
* **Documentation must be included with travel invoice**
* **Travel must comply with current PPM 49 guidance**

**Total Invoice $ XXX,XXX**

**Agency Certification**

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Authorized Agency Representative Date

**Office of Public Health STD/HIV/Hepatitis Program Certification**

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Program Monitor Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Services Manager Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Director, STD/HIV/Hepatitis Program Date