JONES,FRANK PAUL
923 S A AVENUE
ORDER OF ZEWS
AVON PARK FL 33825

29
055

113-52-5383 SM 03041959 509

113525383 5 0 8

VOUCHER FOR CASH REIMBURSEMENT OF BENEFICIARY TRAVEL EXPENSES

1. Patient Data Card Information

2. Name and Address of Issuing Health Care Facility

AUGUSTA VAMC
950 15TH STREET
AUGUSTA, GA 30901-2608

C710477

3. Fiscal Symbols

4. From (Place of Departure)
923 S A AVENUE
ORDER OF ZEWS
AVON PARK, FL 33825

5. To (Destination)
DOWNTOWN DIVISION
950 15TH STREET
AUGUSTA, GA 30901-2608

6. Miles Traveled	7. Authorized Mileage Rate:	8. MileageAllowance (Item 6 X Item 7)	8a. CommonCarrier Fee
56 miles	$0.415 per mile	$23.24	$0.00

9. Meals & Lodging Costs	10. Ferry, Bridges, Etc.	11. Total (Sum of 8, 8a, 9, and 10)
$0.00	$0.00	$23.24

12. Most Economical Public Trans. Costs	13. Total (Sum of 9 and 12)	14. AMOUNT CLAIMED AND PAYABLE *
$0.00	$0.00	MINUS $0.00 APPLIED DEDUCTIBLE $23.24

* The amount payable is the amount entered in Item 14.

I CERTIFY THAT THE CLAIMANT REPORTED FOR AN AUTHORIZED SERVICE ON THE DATE SHOWN. (Authority VA Regulation 6100 & PL 100-322)

15. Date/Time of Claim	16. Signature of Certifying Official
JAN 10,2017@12:05	CARLA D CLEMONS, DESIGNEE OF CERTIFYING OFFICIAL

I have neither obtained transportation at Government expense nor through the use of Government request, tickets, or tokens; and have not used any Government-owned conveyance or incurred any expenses which may be presented as charges against the Dept. of Veterans Affairs for transportation, meals, or lodging in connection with my authorized travel that is not herein claimed. I hereby claim the amount entered in Item 14 above. I certify that the claim is correct and just and that payment has not been received.

I hereby acknowledge receipt, in cash or check to be mailed, of the amount in Item 14 above, in full payment of this claim.

17. Signature of Payee	18. Date
FRANK PAUL JONES	

ACCOUNT: 829

REMARKS: AUG EMERGENCY,PD011017,CDC

TOTAL TRIP	TOTAL MONTHLY DEDUCTIBLE
1 WAY = 1 RT = 0	$0

AUDIT BLOCK

AMOUNT PAID FOUND CORRECT	Remarks
Auditor's Initials Date	

VA Form 70-3542d

RECEIVED $ 23.24

X _____ 1-10-17
PAYEE'S SIGNATURE DATE

PAID
JAN 10 2017
CHARLIE NORWOOD VA MEDICAL CENTER