

**Short Grass Honor Band**  
**Clinician Mileage Claim Form**

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone # \_\_\_\_\_

Mileage (round trip) \_\_\_\_\_ x .50 per mile = \_\_\_\_\_

Signature \_\_\_\_\_

Sign and return to Short Grass president by lunch Tuesday.