

See Instructions and *Privacy
 Statement On Reverse Side

CLAIMANT'S NAME Ellen Feigal		SSN or EMPLOYEE NUMBER* [REDACTED]	DEPARTMENT CIRM
POSITION Senior VP	CB/ID No.	DIVISION or BUREAU Research and Development	INDEX NUMBER
RESIDENCE ADDRESS *		HEADQUARTERS ADDRESS 210 King Street	TELEPHONE NUMBER (415) 396-9106
CITY [REDACTED]	STATE [REDACTED]	ZIP CODE [REDACTED]	CITY San Francisco
			STATE CA
			ZIP CODE 94107

(1) NORMAL WORK HOURS	(2) PRIVATE VEHICLE LICENSE NUMBER [REDACTED]	(3) MILEAGE RATE CLAIMED [REDACTED]
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(4) MONTH/YEAR	(5) DATE	(6) LOCATION WHERE EXPENSES WERE INCURRED	(7) LOGGING	(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
	TIME									MILES	AMOUNT		
12/13	2/20	Los Angeles, CA						50.50				0.00	50.50
	1/23	SF								5.00	23.00	<u>13.00</u> 12.77	<u>18.00</u> 17.77
	1/24	SF								5.00	23.00	<u>13.00</u> 12.77	<u>18.00</u> 17.77
	2/14	SF								5.00	23.00	<u>13.00</u> 12.77	<u>18.00</u> 17.77
	2/15	SF								5.00	23.00	<u>13.00</u> 12.77	<u>18.00</u> 17.77
	2/19	SF								4.00	20.00	<u>11.30</u> 11.10	<u>15.30</u> 15.10
	2/11	SF										0.00	35.91
												0.00	0.00
												0.00	0.00
												0.00	0.00
												0.00	0.00
												0.00	0.00
(13) SUBTOTALS			0.00	0.00	0.00	0.00	0.00	50.50		24.00	112.00	62.16	35.91
COLUMN CODE (ACCTG. USE ONLY)													
CLAIM TOTAL													<u>173.71</u> 172.57

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

2/20 CFAOC Meeting
 1/23, 24 ICOC Board Meeting
 2/14,15 Genomics GWG
 2/19 Meeting with Kaiser Permanente
 2/11 Interview

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 [REDACTED]	DATE 3/12/2013	(16) SIGNATURE OF OFFICER APPROVING TRAVEL AND PAYMENT [REDACTED]	DATE 3.13.2013
(17) SUPERVISOR'S SIGNATURE [REDACTED]	TITLE (See Item 17 on reverse)		DATE