

**College of Pharmacy
In-State Travel Authority**

Authority #: _____

Name: _____

SSN: XXX-XX-_____

Dates to be absent: _____ to _____

If recurring, please provide days, times, frequency, etc...(separate approval for each semester)

Destination:

Address while away: _____

Nature of Business: _____

Means of handling classes and other business while absent:

Mode of Transportation:

State Vehicle

Rental Car

Private Car

Estimated Expenses:

Account #: _____

Lodging: _____

Mileage: _____

Meals: _____

Other Misc.: _____

Total _____

Approved/Non-Approved

Travelers Signature

Date

Department/Unit Head

Date

The individual named above will be traveling on the dates listed, within the State of Georgia or fifty miles of the Georgia border, on official University business.