CS# _____
RE# _____

TRANSPORTATION INVOICE

Ministry of Children & Family Development
550 Lakeshore Dr NE, Box 100 Stn Main
Salmon Arm, BC V1E 4S4
Ph: 250-832-1719 Fax: 250-832-1792

CONTRACTOR(S)/FOSTER PARENT(S):_____

ADDRESS:_____ **PHONE:**_____

CHILD:_____ **CELL:**_____

Note: Once approved. ***Additional mileage claimed is paid at a rate of 51 cents/km driven.***

DATE (y/m/d)	DESTINATION	MILEAGE (kms driven this date/trip)
Please Reimburse Me For:		

A)	TOTAL KMS Driven FOR MONTH:	_____kms	
B)	*MINUS contracted 325 kms*	- 325 kms	
C)	**TOTAL PAYABLE KMS (balance)**	**=_____kms**	**@ .51 = $_____**

_____ _____

Foster Parent(s) Signature **Date**

MCFD OFFICE USE ONLY - QUALIFIED RECEIVER CERTIFICATION –
The goods provided or services delivered have been inspected or reviewed and the goods or services were properly received and supporting documentation verified.

SIGNATURE: _____ ***PRINT NAME:*** _____