Minnesota Aging Pathways
Volunteer Hours / Expense Report

Name:	Quarterly Reporting Months:
Address:	Please submit this report by the last Wednesday of each quarter to: Volunteer Coordinator, Central MN Council on Aging, 3333 W Division St, Ste 217, St. Cloud, MN 56301
City, State, Zip:	

Date	Type of Activity/Event	Hours *	Location	Miles **	Other Allowable Expenses	Total
	Total Hours: 0.0		**Total Miles:** 0		0.725 **Mileage:** 0.00	
* .5 increments ** Round to nearest mile					**Total Reimbursement:** 0.00	

For CMCOA Office use only:
Element Code: _____
GL Code Volunteer Mileage 52400: _____
GL Code Postage 53400: _____
GL Code: _____

Please Note: Our auditor requires that we have receipts for all expenses. Please remember to attach all receipts to receive reimbursement. Thank you.

I declare under penalty of law that this claim is just and correct and that no part of it has been paid or otherwise reimbursed according to IRS Regulations.

_____ Date: _____
(Volunteer signature)

_____
(Coordinator signature)

Updated: 1/2026