MEDICAL TRAVEL REIMBURSEMENT RECORD

Claimant Information:	
Claimant Name:	Claim # _____
Address:	Date of Injury: ___/___/____
PLEASE NOTE YOU MUST FILE WITHIN ONE YEAR OF YOUR DATE OF TREATMENT	

Mileage Reimbursement Information:

DATE	TRAVELLED FROM ADDRESS	NAME & ADDRESS OF MEDICAL SVC	# MILES ROUNDTRIP	PARKING (MUST have receipts attached.)

_____ X _____ = $_____

Total # of Miles Rate Amount of Reimbursement

I certify that the above information is true and correct to the best of my knowledge, and that I have not previously been reimbursed for any of the above trips to this date.

_____

Claimant's Signature

Submit Form to the Office of Risk & Safety.