MILEAGE REIMBURSEMENT FORM

Claimant Name	Social Security Number
Claimant Address	Date of Accident

Date of Travel	Name of Medical Facility	Round-Trip Mileage To & From Residence

I hereby certify or affirm that the above mileage was incurred by me as necessary traveling expenses related to those medical facility visits pursuant to my workers' compensation case.

Claimant's Signature	Today's Date