Fayette County Cancer Society
P. O . Box 480
Connersville, IN 47331
Date Submitted (date mailed) _____
Phone: 765-309-2314

Transportation Form

NAME: **Phone:**

Address:

Date of Trip	Facility/City	Type of Treatment	Medical Personnel Initial Each Visit

Physician or **Medical Personnel Signature:**

Physician or Medical Facility Address:

Physician's or Medical Personnel/Facility Phone Numer:

(You may attach a business card with the contact info.)

To be eligible for payment, milege Must Be turned in within 60 days and form must be signed by your doctor/RN/or other medical personnel who have administered treatment. Also, patient must be in the car for transportation to be counted. Mileage for visits to the patient in the hospital is not eligible for reimbursement. No reimbursement will be made for trips prior to financial aid application date.