**MILEAGE EXPENSES**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Employee Name** | | | | **Date of Injury** | | | | **Claim Number** | |
|  | | | |  | | | |  | |
| **First line provides an example of how to complete the form.** | | | | | | | | | |
| **Date** | **Time** | **From Address** | **To Address** | | **Mileage** | **From Address** | **To Address** | | **Mileage** |
| **1/1/2020** | **12:15 p.m.** | **Work (123 Park Street)** | **MD (123 Provider Lane)** | | **10** | **MD (123 Provider Lane)** | **Work (123 Park Street)** | | **10** |
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I certify that the above mileage was incurred by me while seeking medical attention for my work-related injury. I understand that mileage reimbursement will occur only after mileage dates given by me can be verified by Worker's Compensation.

FOR WORKER’S COMPENSATION EXAMINER USE ONLY

\_\_\_\_\_\_\_\_\_\_ X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ = $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total Miles Current Mileage Rate Mileage Reimbursement Due

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Signature of Employee Date