MILEAGE REIMBURSEMENT FORM

Each time you make a trip to a DOCTOR, THERAPIST, HOSPITAL or PHARMACY, please fill in the information requested below for mileage reimbursement from your carrier.

Date of Trip	Address From	Destination Address	Round-Trip Mileage

I hereby certify and 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. Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s.817.234.

EMPLOYEE SIGNATURE ________________________________ SSN ____________________

EMPLOYEE PRINTED NAME ______________________________

EMPLOYER ____ D/A ____________________