**WORKER'S COMPENSATION MILEAGE RECORD**

**NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDRESS**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLAIM NUMBER**: **DATE OF INJURY**:

**ADJUSTER**: **EMPLOYER**:

|  |  |  |  |
| --- | --- | --- | --- |
| **DATE** | **TRAVELING TO – NAME AND ADDRESS** | **TRAVELING FROM – NAME AND ADDRESS** | **MILEAGE** |
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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.

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 Signature of Employee Date

**FOR WORKER’S COMPENSATION USE ONLY**

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

Total Miles Current Mileage Rate Mileage Reimbursement Due