## **MILEAGE EXPENSES**

Employee Name				Date of In	ijury	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	
certify that the above mileage was incurred by me while seeking medical attention or my work-related injury. I understand that mileage reimbursement will occur nly after mileage dates given by me can be verified by Worker's Compensation.				FOR W	FOR WORKER'S COMPENSATION EXAMINER USE ONLY  = \$			
				Total M	Total Miles Current Mileage Rate Mileage Reimbursement Due			
gnature of Employee Date								