



MILEAGE REIMBURSEMENT

Employee: _____
Employer: _____
Date of Accident : _____
Claim #: _____

****PLEASE COMPLETE EACH SECTION OF THIS FORM FOR EACH DAY MILEAGE REIMBURSEMENT IS BEING CLAIMED.**

NAME AND ADDRESS OF PHYSICIAN OR MEDICAL FACILITY:	DATE (s)	ADDRESS CLAIMANT STARTED FROM:	ADDRESS OF FINAL DESTINATION AFTER DR.'S APPT:	ROUND TRIP MILES:
_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____
_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____
_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____
_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____
_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____

PLEASE DO NOT WRITE IN THIS SPACE

I WISH TO BE REIMBURSED FOR THE ABOVE MILEAGE AT THE PREVAILING RATE OF _____ CENTS PER MILE.

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 is guilty of a felony of the third degree.

Mail to: Division of Risk Management
 Bureau of State Employees' WC Claims
 P.O. Box 8020
 Tallahassee, Florida 32314-8020

Claimant's Signature: _____
 Street Address: _____
 City/State/Zip _____
 Date: _____