

MILEAGE REIMBURSEMENT

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

Social Security #: _____
Employee: _____
Employer: _____
Date of Accident: _____

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 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 felony of the third degree.

<p>Mail to: Division of Risk Management Bureau of State Employees' WC Claims P.O. Box 8020 Tallahassee, Florida 32314-8020</p>	<p>Claimant's Signature: _____ Street Address: _____ City/State/Zip _____ Date: _____</p>
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