MILEAGE REIMBURSEMENT FORM

CLAIMANT NAME	SOCIAL SECURITY NUMBER
CLAIMANT ADDRESS	DATE OF ACCIDENT

DATE OF TRAVEL	NAME OF MEDICAL FACILITY (excluding Pharmacies)	ROUND-TRIP MILEAGE TO & FROM RESIDENCE

I hereby certify and affirm that the above mileage was incurred by me as necessary traveling expenses related ot those medical facility visits pursuant to my workers' compensation case.

An injured employee or any other party making a claim under Florida Statute 440.105(7) shall provide his or her personal signature attesting that he or she has reviewed, understands, and acknowledges the following statement: "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." If the injured employee or other party refuses to sign the document attesting that he or she has reviewed, understands, and acknowledges the statement, benefits, or payments under this chapter shall be suspended until such signature is obtained.

Claimant's Signature	Today's Date