Workers' Compensation
Mileage Reimbursement Request

EMPLOYEE	
EMPLOYEE ADDRESS	
CLAIM #	
DATE OF INJURY	

Date of Visit	Name of Doctor of Facility	Purpose of Visit	Round Trip Mileage

My signature on this form indicates a true representation of mileage and medical trips. I understand any misrepresentation on mileage will be considered Fraud under the Ga Workers' Compensation Statute and subject me to possible fines and imprisonment under Georgia Statute.

Signature	Date: