MILEAGE REIMBURSEMENT

Social Security #: _____

Employee: _____

Employer: _____

Date of Accident: _____

****PLEASE COMPLETE EACH SECTION OF THE 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 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.

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: _____

REV 3/26/1999
D14-866