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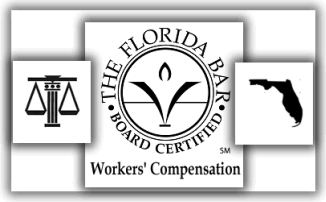

WORKERS' COMPENSATION - MILEAGE CLAIM FORM

List all trips to/from any authorized provider and/or the pharmacy for authorized medications.

Name:	**Date of Accident:**
Home Address:	**Social Security #:**
Home Phone:	**Employer:**

DATE	List trip taken below such as: Home to (name) Hospital; Home to Dr. (name) and return home; Office to Dr. (name) and return home	ROUND-TRIP MILEAGE
	MILEAGE TIMES prevailing IRS rate	

I certify that the above information furnished by me is true and correct and, based on such information, I hereby claim pay for the mileage as indicated.

_____ _____

Signature Date