

MILEAGE LOG

Claimant Name _____
 Claim # _____
 Date of injury _____

Trip date	From address*	To address	Purpose of trip	Number of miles
Date range		Total miles		

* On days when you **are not** working, mileage will be reimbursed only between your home address and the WC clinic.
 On days when you **are** working, mileage will be reimbursed only between your work location and the WC clinic, unless the clinic is on your home campus (in which case there will be no mileage reimbursement).

I verify that the above record is accurate. Please send mileage reimbursements to the following address:

Signature _____ Date _____
 Printed name _____
 Address _____ Phone # _____

Do you need additional Mileage Logs? Yes No