**MILEAGE REIMBURSEMENT**

Employee:       Claim Number:

Please indicate the date of your visit, your starting location, your destination, and the total round-trip miles per visit.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| DATE | FROM | | TO | TOTAL MILES |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |
|  |  | | GRAND TOTAL OF MILES |  |
| TOTAL AMOUNT WHICH IS REQUESTED TO BE PAID BY THE  THE DISABILITY COMPENSATION PROGRAM $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| I HEREBY MAKE CLAIM FOR PAYMENT OF TRAVEL EXPENSES, WHICH HAVE BEEN INCURRED FOR THE FOLLOWING REASON(S): | | | | |
|  | | | | |
|  | | | | |
|  | | | | |
|  | | | | |
|  | | | | |
| I CERTIFY that the INFORMATION provided on this form is TRUE, CORRECT AND COMPLETE to the best of my knowledge, and I UNDERSTAND that the submission of FRAUDULENT INFORMATION may result in PENALTY OF FINE and/or IMPRISONMENT. | | | | |
| Signature of Claimant. | | Date: | | |
| **NOTE WELL: Complete another form if ADDITIONAL SPACE IS REQUIRED,** **DO NOT USE THE REVERSE SIDE!** | | | | |

Form 7.1-051, Rev.1 23-Rev 5/94