GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF RISK MANAGEMENT

Jed Ross
Chief Risk Officer

Public Sector Workers' Compensation Program

FORM 11 – TRANSPORTATION REQUEST AND REQUEST FOR TRANSPORTATION AND TRAVEL REIMBURSEMENT

Please complete "Claimant Information," followed by Part A or Part B. Documentation supporting evidence of expenditures shall be submitted **with this form. Failure to file your request by the deadline will result in the request being denied. The Claimant is responsible for making sure the request is filed by the deadline. No one is authorized to extend the submission deadline. Transportation and reimbursement regulations can be found at 7 DCMR 150.**

Part A: Use Part A to request transportation to or from a physical examination or medical treatment. This request must be received by ORM **five (5)** business days prior to the date of physical examination or medical treatment.

- or -

Part B: Use Part B to request reimbursement of necessary and reasonable transportation expenses. This request must be received by ORM within **thirty (30)** calendar days from the date the expense was incurred. The 2018 reimbursement rate is $0.545 per mile.

CLAIMANT INFORMATION

Claimant's Name: _____
Claimant's Full Address (with unit number, zip code):
_____
_____
_____

Representative (if any): _____
Rep.'s Full Address (with unit number, zip code):
_____
_____
_____

Claimant's Telephone: _____
Claimant's E-mail: _____
Claim Number: _____
Employing Agency: _____

Rep.'s Telephone: _____
Rep.'s Fax: _____
Rep.'s E-mail _____
Date of Injury: _____

PART A. TRANSPORTATION REQUEST (Attach supporting documentation, to include medical documentation that Claimant is unable to drive or use public transportation due to the accepted medical condition, disability or injury.)

Date of Travel: _____ ☐ **One Way** ☐ **Round Trip**

Travel From:	☐ **Hospital**	☐ **Office/Clinic**	☐ **Lab**	☐ **Home**	☐ **Other**
Travel To:	☐ **Hospital**	☐ **Office/Clinic**	☐ **Lab**	☐ **Home**	☐ **Other**

Pick Up Time: _____
Pick Up Location: _____
_____

Return Trip Pick-Up Time: _____
Return Trip Destination: _____
_____

Medical Facility Name and Address:

PART B. <u>REQUEST FOR TRAVEL REIMBURSEMENT</u> (Attach supporting documentation. Reimbursable travel distance may not exceed 50 miles roundtrip.)

Date of Travel: ______________________ ☐ **One Way** ☐ **Round Trip** **Total Expense/Cost:** ☐ **Taxi** __________ ☐ **Bus/Train** __________ ☐ **Tolls/Parking** _______ **Private Auto Miles Traveled:** ________________ **Travel From:** ____ **Travel To:** ____

Date of Travel: ______________________ ☐ **One Way** ☐ **Round Trip** **Total Expense/Cost:** ☐ **Taxi** __________ ☐ **Bus/Train** __________ ☐ **Tolls/Parking** _______ **Private Auto Miles Traveled:** ________________ **Travel From:** ____ **Travel To:** ____

Date of Travel: ______________________ ☐ **One Way** ☐ **Round Trip** **Total Expense/Cost:** ☐ **Taxi** __________ ☐ **Bus/Train** __________ ☐ **Tolls/Parking** _______ **Private Auto Miles Traveled:** ________________ **Travel From:** ____ **Travel To:** ____

Date of Travel: ______________________ ☐ **One Way** ☐ **Round Trip** **Total Expense/Cost:** ☐ **Taxi** __________ ☐ **Bus/Train** __________ ☐ **Tolls/Parking** _______ **Private Auto Miles Traveled:** ________________ **Travel From:** ____ **Travel To:** ____

I have read this Request Form and I swear or affirm that the contents are true and accurate to the best of my knowledge.

CLAIMANT/REP'S SIGNATURE: ______________________________ **DATE:** ______________________

<u>WHERE TO FILE</u>: You **MUST** file your request with the **<u>Office of Risk Management</u> (ORM) by e-mail, mail, fax or in person**. You may file a request in person, weekdays between 8:30 a.m. and 5:00 p.m., or by mail to the following address. You will need photo identification to enter the building:

Office of Risk Management
One Judiciary Square
441 Fourth Street, NW, Suite 800 South
Washington, DC 20001-2714
E-mail: wcsecure@dc.gov
Fax: 202-535-1130
Your request must be received by ORM by the submission deadline.

SUBMIT THIS FORM TO YOUR IMMEDIATE SUPERVISOR AND THE PSWCP.