**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.

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| --- | --- | --- | --- |
| DATE | FROM | TO | TOTAL MILES |
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|  |  |  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): |
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| 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