# MILEAGE REIMBURSEMENT

**Social Security #:** _____

**Employee:** _____

**Employer:** _____

**Date of Accident:** _____

****PLEASE COMPLETE EACH SECTION OF THE FORM FOR EACH DAY MILEAGE REIMBURSEMENT IS BEING CLAIMED**

| NAME AND ADDRESS OF PHYSICIAN OR MEDICAL FACILITY: | DATE (S) | ADDRESS CLAIMANT STARTED FROM: | ADDRESS OF FINAL DESTINATION AFTER DR'S APPT: | ROUND TRIP MILES |
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**PLEASE DO NOT WRITE IN THIS SPACE**

**I WISH TO BE REIMBURSED FOR THE MILEAGE AT THE PREVAILING RATE OF _____ CENTS PER MILE**

***Any person who knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company or self-insured program files a statement of claim containing any false or misleading information is guilty of felony of the third degree.***

**Mail to:** **Division of Risk Management**
**Bureau of State Employees' WC Claims**
**P.O. Box 8020**
**Tallahassee, Florida 32314-8020**

**Claimant's Signature:** _____
**Street Address:** _____
**City/State/Zip** _____
**Date:** _____

**REV 3/26/1999**
**D14-866**