MILEAGE REIMBURSEMENT

RE: WORKERS' COMPENSATION CLAIM:

Employee: **Examiner:**
Employer: GA Municipal Association
Social Security #: n/a
Date of Injury:
Claim No.:

Date	To/From	Purpose	Mileage

I certify that the above is a true and accurate representation of my travel to and from medical treatment facilities.

_____ _____
Signature **Date**

_____ _____
Street Address **City, State, Zip Code**