WORKERS COMPENSATION
TRAVEL REIMBURSEMENT FORM

NAME:
DATE OF INJURY:
HOME ADDRESS:
CLAIM NUMBER:
EMPLOYER:

Please list total amount of mileage, round-trip from your home to the hospital, physician and etc. Travel is reimbursed in accordance with the Alabama Workers Compensation Code 25-5-77.

DATE OF TRIP	DESCRIPTION	TOTAL MILEAGE

TOTAL MILEAGE ________________

TOTAL MILEAGE = $ ________________

I certify that the above information is true and correct.

SIGNATURE_____________________________________ DATE___________________