MILEAGE REIMBURSEMENT FORM

EMPLOYEE: _____ DATE OF INJURY: _____

EMPLOYER: _____ CLAIM #: _____

	DATE	STARTING LOCATION	DESTINATION (DOCTOR / FACILITY)	ROUND TRIP MILES
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
			TOTAL MILES	
			*AMOUNT PER MILE	X
			REIMBURSEMENT AMOUNT	$

Mileage is reimbursed at the following rates for the following periods.

Rate	Period	Rate	Period
$0.340	10/1/2001 to 6/30/06	$0.445	7/1/06 to 12/31/06
$0.485	1/1/07 to 12/31/07	$0.505	1/1/08 to 6/30/08
$0.585	7/1/08 to 12/31/08	$0.55	1/1/09 to 12/31/09
$0.50	1/1/10 to 12/31/10	$0.51	1/1/11 to 6/30/11
$0.555	7/1/11 to 12/31/12	$0.565	1/1/13 to 12/31/13
$0.56	1/1/14 to 12/31/14	$0.575	1/1/15 to 12/31/15
$0.54	1/1/16 to present		