

Return to: Mark Lee, Esq.

3903 Northdale Blvd, Suite 100e
 Tampa, Florida 33624
 813-321-0426
 813-324-2885 Facsimile

WORKERS' COMPENSATION - MILEAGE CLAIM FORM

List all trips to/from any authorized provider and/or the pharmacy for authorized medications.

Name:	Date of Accident:
Home Address:	Social Security #:
Home Phone:	Employer:

DATE	List trip taken below such as: Home to (name) Hospital; Home to Dr. (name) and return home; Office to Dr. (name) and return home	ROUND-TRIP MILEAGE
Total Mileage		

I certify that the above information furnished by me is true and correct and, based on such information, I hereby claim pay for the mileage as indicated.

Signature

Date