MEDICAL TRAVEL EXPENSE FORM

Claimant's Name: _____
Street Address: _____
City: _____
State and ZIP: _____
Date of Injury: _____

You are entitled to reimbursement of medical travel expenses incurred because of your on the job injury. Complete the appropriate boxes below. Copies of supporting documents should be attached, for example: parking, cab, toll receipts. This form may be photocopied. You should keep a copy for your records and forward the original to your attorney. Please contact your attorney if you have any questions regarding this form.

DATE	TRAVELED FROM (Include Address)	TRAVELED TO (Include name & address of medical provider)	ROUND TRIP MILEAGE	PARKING (Attach Receipts)	TOLLS (Attach Receipts)	PUBLIC TRANS./ OTHER (Attach Receipts)
EXAMPLE 10/15/09	HOME - 144 Main Street Anytown, MD	Dr. Jim Smith, 589 Oak Street Anytown, MD	14	$2.50	$3.00	$2.00
TOTALS				$	$	$