Employee:

Employer: **USNH-University of New Hampshire**

Claim No. #

Date of Injury:

You are entitled to reasonable reimbursement of medical travel expenses incurred because of your work related/occupational illness injury. Please record the dates of your appointments and round trip mileage to and from your doctor’s office, trip to the hospital, or trips to obtain x-rays, medication or lab tests. If you need more space, please use the back of this sheet or attach another.

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| --- | --- | --- | --- |
| **DATE** | **TRAVELED FROM (Address)** | **TRAVELED TO**  **(Include name and address of doctor, physical therapy, hospital, etc.)** | **ROUND TRIP MILEAGE** |
| *Sample*  *01/01/08* | *7755 Maple Street*  *Dover, NH 03824* | *Dr. Smith 378 Main Street*  *Dover, NH 03824* | *12* |
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This is a true and accurate account of my expenses. I am aware that it is a felony for any person to knowingly misrepresent any fact in order to obtain workers’ compensation benefits.

**SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**