Mail to:
Insurance Carrier Name: _____ State File #: _____
Insurance Carrier Address: _____ Ins. Co. File #: _____
Insurance Carrier City/State/Zip: _____ Date of Injury _____
Insurance Carrier Adjuster: _____

Mileage Reimbursement Request

Employee Name _____ Employer Name _____

Employee Address _____ Employer Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Daytime Phone _____ Employer's Phone _____

Worksite Address: _____

You are eligible for mileage for medical appointments, insurer scheduled visits or vocational rehabilitation. (WC Rule 4.1300 and VR Rule 58.7100)

Date/Time of Visit	Who/Where Visited – Official Name	Traveled From (City/Town)	Traveled To (City/Town)	Reimbursable Mileage

I hereby affirm that all mileage listed above was for travel required regarding a valid workers' compensation claim:

_____ _____
Signature Date

Current mileage reimbursement rates are available at: http://labor.vermont.gov/wordpress/wp-content/uploads/mileagemealreimb.pdf