MILEAGE REIMBURSEMENT REQUEST

EMPLOYER: ______________________________
EMPLOYEE: ______________________________
SOCIAL SECURITY NUMBER: ______________________________
DATE OF LOSS: ______________________________

Under the provisions of Florida Workers' Compensation Act, you are entitled to reimbursement for mileage to and from your doctor's office or place of medical treatment. If you wish to be reimbursed for this expense, please fill in all lines below. When your trips have been confirmed with the treating facility, you will be reimbursed at $0.29 per mile. If you require additional forms, please advise.

COMPLETE AND RETURN TO:

Johns Eastern Co., Inc.
P.O. Box 3318
Sarasota, FL 34230

DATE	FROM (Address)	TO (Name & Address)	ROUNDTRIP MILES

Any person who knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement or claim containing any false or misleading information, is guilty of a felony of the third degree.

______________________ ______________________
DATE SIGNATURE