



PO Box 624, Tiffin, OH 44883
419.937.2540

Transportation Mileage Form

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____

#	Date	Name of Treatment Center	Mileage	Signature of Attendant
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
		Total Monthly Miles =		X .35 =

Return completed and signed form to above address. Checks are generally written twice a month on no particular schedule. Your reimbursements may take up to 2-3 weeks based on when checks were last written.

Due to Board Policy, we cannot make reimbursement for any receipts or transportation that is 6 months or older.