GWINNETT COUNTY PUBLIC SCHOOLS

WORKERS' COMPENSATION
MILEAGE REIMBURSEMENT REQUEST

EMPLOYEE NAME: _____

EMPLOYEE ID: _____

WORK LOCATION: _____

INJURY DATE: _____

Date of Visit	To	From	Roundtrip Miles
		Total Miles:	
			x .40
		Total Travel Reimbursement Requested:	

Payment will only be made for trips made within the prior 12 months (one year), as specified in O.C.G.A. §34-9-203.

I certify that the above information is true and correct to the best of my knowledge, and that I have not previously received reimbursement for any of the trips listed above.

_____ _____

Employee's Signature Date