MILEAGE REIMBURSEMENT FORM

Claim Number:

Name: Employer: COLORADO STATE UNIVERSITY

Address:

DATE	FROM	DESTINATION	ROUND TRIP MILES	PURPOSE
		TOTAL MILES:		

I certify that the statements in the above schedule are true and correct in all respects; that payment of the amounts claimed herein has not and will not be reimbursed to me from any other sources; that travel, for which reimbursement is claimed, was performed by me for medical treatment and that no claims are included for expenses of a personal or political nature or for any other expenses not authorized by Workers' Compensation; and that I actually incurred or paid the operating expense of the motor vehicle for which reimbursement is claimed on a mileage basis. I am aware that I may be prosecuted for fraud if the information I have provided is falsely documented.

Signature: _____ Date: _____

Total to be reimbursed: Miles _____ @ .53 (cents) per mile = $ _____

Return to: Gallagher Bassett, PO Box 2831, Clinton, IA 52733-2850
(Keep a copy of the completed form for you records)