GWINNETT COUNTY PUBLIC SCHOOLS

## WORKERS' COMPENSATION
# MILEAGE REIMBURSEMENT REQUEST

**EMPLOYEE NAME:** _____

**EMPLOYEE ID:** _____

**WORK LOCATION:** _____

**INJURY DATE:** _____

| Date of Visit | To | From | Roundtrip Miles |
|---|---|---|---|
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| | | Total Miles: | |
| | | | x .45 |
| | | 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