

# For Work Related Injuries Only

## Mileage Worksheet for Medical Treatment — Examination — Physical Therapy — Laboratory Test

[Section 31-312 C.G.S.]

Rev. 3-17-2006

Employee Name \_\_\_\_\_ Date of Injury \_\_\_\_\_ Claim # \_\_\_\_\_  
(Please TYPE or PRINT IN INK)

Employer Name \_\_\_\_\_

DATE: Month / Day / Year	FROM: City / Town , State	TO: City / Town , State	REASON FOR VISIT — NAME OF PHYSICIAN or Other Health Care Provider	ROUND-TRIP MILEAGE:
/ /				
/ /				
/ /				
/ /				
/ /				
/ /				

DATE SUBMITTED \_\_\_\_\_ TOTAL MILEAGE # \_\_\_\_\_