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 = ________