COUNTY OF HENRICO
WORKERS' COMPENSATION
REIMBURSEMENT FOR MILEAGE EXPENSES

Employee's Name_____

Employee's Address_____

Date of Injury _____

Department_____

Date of Trip	Name of Medical Provider	Medical Provider's Address	Round Trip Miles
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
		TOTAL MILES:	_____

I hereby certify that the foregoing claim for reimbursement of mileage expenses is true and correct.

Signature of Claimant_____ Date_____

Form WC-5
May, 2003