COUNTY OF HENRICO
WORKERS' COMPENSATION
REIMBURSEMENT FOR VOCATIONAL MILEAGE EXPENSES

Employee's Name_____ Employee's Address_____

Date of Injury _____ Department/School _____

*Your signature will confirm that our employee has contacted you in-person for a potential employment opportunity

Date of Visit	Name of Company Visited	Address/Phone of Company Visited	Name/*Signature of Contact Person	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-5v
September 2012