DUFFERIN COUNTY

COMMUNITY SERVICES

MEDICAL TRANSPORTATION AND TRAVEL EXPENSE FORM

Name _____ **Month/Year** _____

Check List: ☑ Check that you have attached the following documents:

☐ Verification of Medical Appointment (s)	☐ Recommendation for Treatment *(if required)*	☐ Receipts for Parking, Meals, Accommodation

MILEAGE REIMBURSEMENT: Complete the chart below for reimbursement of mileage based on $0.40 per kilometer

DATE	PLACE	PURPOSE	KM's
		Total Kilometers	
		Total Kilometers x $0.40/km	

OFFICE USE ONLY

Case Worker #_____ Signature of CW _____Approved _____

COUNTY OF DUFFERIN
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