GEORGIA ADMINISTRATIVE SERVICES
1775 Spectrum Drive Suite 100 Lawrenceville, GA 30043
WORKERS' COMPENSATION – MILEAGE CLAIM

NAME:_____ **EMPLOYER NAME:** _____

HOME ADDRESS:_____ **GAS CLAIM #:**_____

HOME PHONE #:_____ **DATE OF INJURY:**_____

DATE	List trip taken below: (examples -- *Home to (name) Hospital; Home to Dr. (name) and return home; Office to Dr. (name) and return home, etc)*	Odometer reading start	Odometer reading end	Total mileage (round trip)

TOTAL MILEAGE _____

TOTAL MILEAGE TIME .45 EACH $_____

I certify that the above information furnished by me is true and correct and based on such information, I hereby claim pay for the mileage indicated.

_____ _____
Signature Date