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 = _____