

NO STAPLES IN
BAR CODE AREA



TRAVEL REIMBURSEMENT REQUEST

Dept. of Labor & Industries
PO Box 44267
Olympia WA 98504-4267

DO NOT
WRITE IN
SPACE

Injured Worker Information

Worker's name (Last, First, Middle Initial)		Claim No.
Worker's home address (not PO Box) Apt #		Date of injury
City	State	Social Security No. (for ID only)
	ZIP	Worker's Phone Number

Travel Information

Why did you travel? If you check more than 1 box, you must use a separate form for each type of travel.

- I traveled for a medical visit or to receive treatment
 I traveled to receive retraining
 I traveled to receive vocational services



Read the instructions on the back of this form before you complete this section.

A	B	C	D		E	F	G
Date (Each Trip or expense)	Travel Code (one per line) See back	From: (City)	To: (City)	Person Seen, Purpose of Trip (Signature of person seen required below)	No. Of Miles (Round Trip)	MILEAGE COST (miles x rate)	Cost For Food, Lodging, Fares, Parking (one per line)
1.						\$	\$
2.						\$	\$
3.						\$	\$
4.						\$	\$
5.						\$	\$
6.						\$	\$
7.						\$	\$
8.						\$	\$
Totals						\$	\$

Signature Requirements:

Signature of the person you traveled to see: 1) Medical Visits - the person you saw must sign to verify each date you traveled. 2) Vocational and Retraining services - your vocational counselor must sign to verify each date you traveled.

Date and authorizing signature of person visited	Date and authorizing signature of person visited	Date and authorizing signature of person visited
1. _____	4. _____	7. _____
2. _____	5. _____	8. _____
3. _____	6. _____	

Worker's Signature (forms not signed will be returned)

These expenses are related to my worker's compensation claim and I have not been reimbursed for them. I understand it is a crime to submit information I know is false. I have read and understand the instructions on the back of this form.

Date	Worker's signature
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