ITEMIZED STATEMENT FOR TRAVEL EXPENSES

Employee	Injury/Illness date
Employer	

Trip date	Physician/Hospital/Therapist	City	Round-trip mileage
		Total mileage	

I hereby certify that I have incurred expenses as listed herein as a result of my workers' compensation injury/illness. I understand that any false information submitted with the intent to defraud the employer/servicing agent is insurance fraud, a third-degree felony under Florida law.

Employee Signature _____ Date _____

Claims Center

P.O. Box 2928 – Lakeland, FL 33806-2928 – (863) 665-6629 – 1-800-282-7644