Social Services Department

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MEDICAL TRAVEL MILEAGE SHEET
FOR THE PERIOD OF _____16TH TO _____ 15TH

Name of Client | Member ID | Caseworker

Date	Roundtrip Distance(kms)	Address and phone # of Appointment / Doctor / Specialist	Driver (name, address, phone number)	Verified By (Please print name & sign) or include appointment card
Total kms		**x $0.28 = $**		

SIGNATURE _____ DATE:_____

If you have any parking receipts, remember to submit them along with this mileage sheet for reimbursement.
PLEASE SUBMIT MILEAGE SHEET(S) WITH YOUR INCOME REPORTING STATEMENT EACH MONTH.

PLEASE NOTE: Medical transportation costs totalling $14.99 or less in any given month will be the responsibility of the client and will not be reimbursed by Ontario Works.