Travel Claim Form

Worker's Name	Claim Number
Date of Injury	**Employer Name**

Make/Model of Car:	
Litre Capacity of Car:	

Date of Travel	From Address	To Address	KM's Travelled	Service Provider's Name e.g. GP, Physio etc.
		Total		

NOTE: Pursuant to the Workers Rehabilitation and Compensation Act 1988, only the reasonable cost of travel for medical treatment will be reimbursed. All journeys claimed must be verified and all accounts in our possession will be checked before the reimbursement occurs. We will also accept the provider's signature against all journeys claimed as verification.

I declare that the above is a true account of expenses incurred by me when travelling to medical appointments in relation to my claimed work injury.

Signature: ___________________________ Date:

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