

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
CLAIMANT'S RECORD OF MEDICAL AND TRAVEL EXPENSE

INJURED WORKER:
EMPLOYER:
ACCIDENT DATE:
WCB CASE NO.:
CARRIER CASE NO.:

SOC SEC NO.:
INJURY:

	NAME OF DOCTOR	VISIT DATE	ROUND TRIP MILEAGE
1			
2			
3			
4			
5			
6			
7			
8			
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20			

MAIL THIS FORM TO THE ADDRESS BELOW (keep a copy for your records):

NOTE: Mileage is not paid for attendance at hearings. Rate is \$.375/mile for 2004; \$.405/mile for 2005.