MURFEE MEADOWS, INC.
MILEAGE REIMBURSEMENT CLAIM

Employer: LEON COUNTY SCHOOLS

Date: _______________

Employee Name: ____

Social Security Number: ____

Date of Trip: ____

Destination From and To: ____

Number of Miles x .19/mile: ____

Name of Health Care Provider: ____

I CERTIFY that the above information is correct and complete. I also CERTIFY that I have not been reimbursed from any other source.

___________________________________ ______________________________

Signature Date

Complete and send to Wendy Gann at Murfee Meadows, Inc. for reimbursement. FAX 205-871-9519 or scan to wendygann@murfeemeadows.com.