NAME: _____ **VWC FILE #:** _____

D/A: _____ **CLAIM #:** _____

MILEAGE AND PRESCRIPTION RECORD

Please record the following information for each visit to a doctor or other medical facility for any treatment received, including physical therapy. You may also include mileage incurred for vocational rehabilitation training.

Date of Treatment	Name of Facility	Miles Traveled Roundtrip

Please record the following information for any prescriptions or other prescribed medical needs.
Receipts for each prescription must be attached along with the completed form

Date	Specific Name of Medication or Product	Amount