Virginia Workers' Compensation Commission

Transportation/Travel Expense Form

Access your claim online: webfile.workcomp.virginia.gov

Jurisdiction Claim Number (JCN)	Claim Administrator Number

Injured Worker Information

Name			Date of Injury/Occupational Disease		
Address			City	State	Zip Code

Mileage Log

Date	Miles Traveled	Address From/Address To
		From:
Purpose of Travel		To:
Date	Miles Traveled	From:
Purpose of Travel		To:
Date	Miles Traveled	From:
Purpose of Travel		To:
Date	Miles Traveled	From:
Purpose of Travel		To:
Date	Miles Traveled	From:
Purpose of Travel		To:

Do you have additional transportation/travel expenses? *(attach receipts)* ☐ Yes ☐ No

Claims for transportation/travel expenses must include medical documentation.
Have you included medical documentation proof for each visit? (attach documentation) ☐ Yes ☐ No

Signature

I hereby certify that the above information is true and that the reimbursement requested is for travel made by me for the treatment of my accepted condition.

SIGNATURE DATE