LANARK COUNTY

SOCIAL SERVICES

# Medical Mileage Form

**Please complete this form and attach Doctor's appointment cards as verification. Parking receipts must be attached, if being claimed.**

**This claim form must be submitted to your Caseworker, to be considered for reimbursement.**

| Dr.'s Name | From | To | Kilometers |
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| **Total Kilometers for month** | | | |

**Please print name:** _____

**Member ID:** _____

**Signature:** _____

**Date:** _____