



**Guideline Name:** Medical Travel Reimbursement Form

**Guideline Owner:** Human Resources

**Effective Date:** January 1, 2026

## MEDICAL TRAVEL REIMBURSEMENT FORM

### Section A. Traveler's Information

1.a Name of Person Claiming Travel Reimbursement (*Last, First,*)

### Section B. Trip Information

1.a I am claiming travel reimbursement from address: <i>(Street, City, State, Zip)</i>	1.b Date Trip Began <i>(mm/dd/yyyy)</i>	1.c Travel by: <i>(e.g., car, train, bus, taxi)</i>
2.a I am claiming return travel reimbursement to the address in B.1.a above  <div style="display: flex; justify-content: space-between;"> <span>YES</span> <span>NO <i>(if no, provide the Street, City, State, Zip below)</i></span> </div>	2.b Date Trip Ended <i>(mm/dd/yyyy)</i>	2.c Travel by: <i>(e.g., car, train, bus, taxi)</i>

3. I am claiming reimbursement of expenses other than mileage, such as tolls, parking, lodging, meals. YES NO

*(If yes, itemize expenses below and provide a receipt for each expense claimed. Use page 2 if additional space is required)*

- a. 

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- b. 

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- c. 

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- d. 

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- e. 

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- f. 

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- g. 

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- h. 

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### Section C. Certification

**Certification: I certify that the above information is correct. I understand that false information can lead to disciplinary action up to and including termination.**

Signature of Claimant	Date (mm/dd/yyyy)
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