

**FAMILY SUPPORT SERVICES MEDICAL MILEAGE REPORT
SCHOOL OF HOPE
1001 CASTALIA STREET
FREMONT, OHIO 43420**

Name of Child _____

Date: Month / Year _____

DATE	BEGINNING MILEAGE	ENDING MILEAGE	TOTAL MILEAGE	X .40 PER MILE	PHYSICIAN/CLINIC & ADDRESS
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/ /					
/ /					
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/ /					
/ /					
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/ /					
/ /					
/ /					
TOTALS					

(** ALL INFORMATION MUST BE COMPLETED BEFORE PAYMENT WILL BE MADE**)
(***** MILEAGE RECORD MUST BE SUBMITTED BY THE END OF EACH MONTH *****)

Driver's Name: _____ Less Family Co-pay: (_____ %)

Driver's Address: _____ Amount Approved: _____

City/State/Zip: _____ Amount to be Paid: _____

I hereby certify that the above miles were incurred by me, in traveling to and from doctor/medical appointments.

SIGNATURE

APPROVED

DISAPPROVED

FAMILY RESOURCE COORDINATOR