



**MEDICAL TRAVEL MILEAGE SHEET**  
**FOR THE PERIOD OF \_\_\_\_\_ 16<sup>TH</sup> TO \_\_\_\_\_ 15<sup>TH</sup>**

Name of Client \_\_\_\_\_ Member ID \_\_\_\_\_ Caseworker \_\_\_\_\_

Date	Roundtrip Distance(kms)	Address and phone # of Appointment / Doctor / Specialist	Driver (name, address, phone number)	Verified By (Please print name & sign) or include appointment card
Total kms		x \$0.20 = \$ _____		

SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_

If you have any parking receipts, remember to submit them along with this mileage sheet for reimbursement.  
**PLEASE SUBMIT MILEAGE SHEET(S) WITH YOUR INCOME REPORTING STATEMENT EACH MONTH.**

PLEASE NOTE: Medical transportation costs totalling \$14.99 or less in any given month will be the responsibility of the client and will not be reimbursed by Ontario Works.

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