Georgia Vocational Rehabilitation Agency
Vocational Rehabilitation Program

Provider Reimbursement Mileage Log

NOTE: This form must be submitted to VR staff issuing authorization with all other required documentation for mileage reimbursement.

Participant _____

Provider Business Name: _____

Driver's Name & Address _____

Amount being paid per mile _____ Contract Service Agreement? ☐ Yes ☐ No

Date of Travel Mo./Day/Yr.	Purpose of Trip	Beginning Address	Ending Address	Beginning Odometer	Ending Odometer	Commute Miles	Total Mileage
1)							
2)							
3)							
4)							
5)							
6)							
7)							

Driver Signature _____ Date _____

"By my signature, I certify this is an accurate account of my attendance and mileage record."

VR Staff Authorizing _____ Date _____

"By my signature, I certify this is an accurate account of travel that has been verified by Map Quest."

Date of Travel Mo./Day/Yr.	Purpose of Trip	Beginning Address	Ending Address	Beginning Odometer	Ending Odometer	Commute Miles	Total Mileage
8)							
9)							
10)							
11)							
12)							
13)							
14)							
15)							
16)							
17)							
18)							
19)							
20)							
21)							
22)							
23)							
24)							

Driver Signature _____ Date _____

"By my signature, I certify this is an accurate account of my attendance and mileage record."

VR Staff Authorizing _____ Date _____

"By my signature, I certify this is an accurate account of travel that has been verified by Map Quest."

Date of Travel Mo./Day/Yr.	Purpose of Trip	Beginning Address	Ending Address	Beginning Odometer	Ending Odometer	Commute Miles	Total Mileage
25)							
26)							
27)							
28)							
29)							
30)							
31)							
					Grand Total		

Driver Signature _____ Date _____

"By my signature, I certify this is an accurate account of my attendance and mileage record."

VR Staff Authorizing _____ Date _____

"By my signature, I certify this is an accurate account of travel that has been verified by Map Quest."