**Medical Travel and Transportation Request Form**

**Physician/Clinic Visits**

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| --- | --- | --- | --- | --- |
| **Client Name** |  |  | **Date of Birth** |  |
|  |  |  |  |  |
|  |  |  | **Employment** |  |
| **Caseworker** |  |  | **Services Worker** |  |
|  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date of****Appointment** | **Method of Transportation**(e.g., car, bus) | **Total KM Travelled** | **Cost of Expenses Incurred**(e.g., bus tickets, parking) | **Physician/Clinic**(clinic stamp required for each visit) |
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| --- | --- | --- |
|  |  |  |
| **Client Signature** |  | **Date** |

***Receipts must be submitted to your worker within 30 days for all benefits issued or an overpayment may be created***

**Medical Travel and Transportation Request Form**

**Trips to Pharmacy/Clinic for Methadone Maintenance Treatment**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Client Name** |  |  | **Date of Birth** |  |
|  |  |  |  |  |
|  |  |  | **Employment** |  |
| **Caseworker** |  |  | **Services Worker** |  |
|  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date of****Appointment** | **Method of Transportation**(e.g., car, bus) | **Total KM Travelled** | **Cost of Expenses Incurred**(e.g., bus tickets, parking) | **Physician/Clinic**(clinic stamp required for each visit) |
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| --- | --- | --- |
|  |  |  |
| **Client Signature** |  | **Date** |

***Receipts must be submitted to your worker within 30 days for all benefits issued or an overpayment may be created***

*Last update October 2018*