

N.E.T. MILEAGE RECORD FOR THE MONTH OF: _____ YEAR: _____

Name & Address of Person going to the appointment: _____
 (Reimbursement is to/from this address only)

Date of appointment	Start Location (Full Address)	Odometer- Start	End Location (Full Address)	Odometer-End	Total Miles Traveled
	From:		To:		
	From:		To:		
	From:		To:		
	From:		To:		
	From:		To:		
	From:		To:		

Please print:

Driver's Name: _____

Driver's Mailing Address: _____

The undersigned agrees that the above information is true and accurate:

* _____
 Driver's signature

****PLEASE ATTACH REQUIRED VERIFICATION SLIPS, PROOF OF CURRENT CAR INSURANCE, AND A COPY OF THE TRANSPORTER'S VALID DRIVER'S LICENSE.**

Remit to: CCDJFS
 Attn: NET Coordinator
 7989 Dickey Dr., Ste. # 2
 Lisbon, OH. 44432

DO NOT WRITE IN THE AREA BELOW:

Office use only: Total Miles _____ x.48 = _____

Driver's Vendor number _____