

KIDNEY FOUNDATION OF NORTHWEST OHIO

3100 W. Central Ave., Ste. 250, Toledo, Ohio 43606

(419) 329-2196

(419) 531-6080 fax

MILEAGE REIMBURSEMENT

NAME: _____

ADDRESS: _____

CITY/STATE: _____ ZIP _____

PHONE: (____) _____

ONE ROUND TRIP ODOMETER READING

_____ BEGINNING MILEAGE

_____ ENDING MILEAGE

Please indicate:

Dates Traveled:

Month Travel Occurred: _____

Purpose of Travel:

Hemodialysis _____

CAPD / CCPD Clinic _____

Transplant Clinic _____

Other _____

(please specify)

Signature

Date

REMINDER:

In order for your reimbursement check to be processed by the 20th, you must return this form to the Kidney Foundation of Northwest Ohio by the 5th of the month following the month travel occurred.

For Office Use Only-Do Not Write Below

Months Approved: _____

Round Trip Mileage: _____

Total Trips _____ x _____ miles = _____

@ .18 per mile = \$ _____

Maximum Approved \$ _____

Amount Reimbursed \$ _____