Premier
Financial Management Services

OREGON VETERAN DIRECTED CARE TRAVEL REIMBURSEMENT LOG

Worker Name: _____

Veteran Name: _____ ID Number: _____

Date	Purpose	From	To	Mileage
			Total Miles:	

By signing this form, I certify that my vehicle is safe for transport and that I have a valid driver's license and insurance.

Worker Signature: _____ Date: ____/____/_____

Veteran/Employer of Record Signature: _____ Date: ____/____/_____

Mileage Log Submission:

Mail:
10425 W North Ave.
Suite 345
Milwaukee, WI 53226

Email:
ORVSDP@premier-fms.com

Fax:
1-855-571-7670

Rev. 6/20