MICHIGAN STATE UNIVERSITY
WORKERS' COMPENSATION
MEDICAL TRAVEL REIMBURSEMENT REQUEST

DATE OF VISIT	NAME OF DOCTOR/HOSPITAL	PURPOSE OF VISIT	NUMBER OF ROUND TRIP MILES

Date: _____

TOTAL 0_____

Signed: _____

Address: _____

_____
City **State** **Zip**

Return to: **Workers' Compensation**
1407 S. Harrison, Room 110
East Lansing, MI 48823