State Accident Fund
Mileage Reimbursement Form

Injured Worker Name:  
Home Address:  
Employer: CLEMSON UNIVERSITY  
Claim No:  
Date of Accident:  

Mileage Reimbursement Form

*Mileage must be more than 10 miles round trip*

01/01/2010 – 12/31/2010 = .50; 01/01/2011 – 06/30/2012 = .505; 07/01/2012 – 12/31/2012 = .555;
01/01/2013 – 12/31/2013 = .565; 01/01/2014 – 12/31/2014 = .56; 01/01/2015 – 12/31/2015 = .575;
01/01/2016 – 12/31/2016 = .54; 01/01/2017 – 12/31/2017 = .535; 01/01/2018 – 12/31/2018 = .545;
01/01/2019 – 12/31/2019 = .58; 01/01/2020 – 12/31/2020 = .575; 01/01/2021 – 12/31/2021 = .56;
01/01/2022 to present = .585

Please include the following:
From: full address (street, city, state, zip code)
To: full address of the facility/doctor (street, city, state, zip code)
Round Trip Miles  Rate  Total SAF use only

<table>
<thead>
<tr>
<th>Date of Trip</th>
<th>From:</th>
<th>To:</th>
<th>From:</th>
<th>To:</th>
<th>From:</th>
<th>To:</th>
<th>From:</th>
<th>To:</th>
<th>From:</th>
<th>To:</th>
</tr>
</thead>
</table>

Signature of Injured Worker: _____________________________  Date:_____________

Remit to: Clemson University Risk Services 391 College Ave, Ste 202, Clemson, SC 29634 email to:wcriskmanagement@clemson.edu

State Fund will compare all submitted roundtrip mileage to Google Maps Driving Directions. It is recommended that you wait at least 30 days before submitting mileage so the proper documentation can be received from the Physician’s office.
If this form is not completed in its entirety it will be returned.