State Accident Fund

Mileage Reimbursement Form

Injured Worker Name: _____ **Claim No:** _____

Home Address: _____ **Date of Accident:** _____

Employer: CLEMSON UNIVERSITY

Mileage must be more than 10 miles round trip

Rate: 01/01/2024 - 12/31/2024 = .67*; **01/01/2025 - Present = .70***

Date of Trip	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**
	From: To:			
	From: To:			
	From: To:			
	From: To:			
	From: To:			
	From: To:			
	From: To:			
	From: To:			

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.