ACCESS SAN JOAQUIN Volunteer Incentive Program (VIP)

REQUEST FOR MILEAGE REIMBURSEMENT

Mail to: Access San Joaquin, Attn: Mobility Department
P.O. Box 201010
Stockton, CA 95201
209.943.1111 | (209) 948-3024 (Fax) | access@sjRTD.com | access-sj.com

This form must be submitted to VIP by the 10th of the month following the trips. Save blank form and make copies as needed.

Date	Driver	Medical Facility	Starting Address	Destination Address	Is this a one-way or round trip?	Total miles	Length of Trip (hours, minutes)

I confirm the truth of this claim and acknowledge that wrongfully completing the form constitutes fraud which could be prosecuted to the full extent of the law. I understand I may be requested to provide proof of trips for auditing purposes. Upon receipt of the reimbursement check for this month I will transfer prompt payment to my volunteer driver(s).

Driver Name: _____ Driver Signature: _____ Date: _____

Driver Name: _____ Driver Signature: _____ Date: _____

Driver Name: _____ Driver Signature: _____ Date: _____

Passenger Name: _____ Passenger Signature: _____ Date: _____

Passenger Address: _____

Please print LEGIBLY. Forms not postmarked by the 10th or filled out completely may not be honored.
Valid only for MEDICAL TRIPS within San Joaquin County.