PRO Disability

Mileage Claim Form

Employer's Name:	Month/Year
Employee's Name:	

Date	From	To	Purpose of journey	Number of miles to be paid
			Total Number of Miles to be Paid @ £0.40 per mile:	

I certify that the journeys have been carried out necessarily and that the entries are correct. I certify that I currently hold a full valid driving license and my motor car Insurance Policy covers use for business mileage, carrying official passengers:

Employee's Signature:	Date:
Checked and Authorised for Payment:	
Employer's Signature:	Date: