Lions Eye Foundation of California-Nevada, Inc.
P.O. Box 7999
San Francisco, CA 94120

PRESERVING THE GIFT OF SIGHT

TRANSPORTATION REIMBURSEMENT REQUEST FOR ______ MO/YR

CLUB NAME ___________________ DISTRICT _____ ONE WAY MILEAGE ______

PATIENT NAME	CHECK IF CHILD	DATE SCHEDULED

We certify that the above information is true and correct

________________________ ____________________

President Secretary or Treasurer

INSTRUCTIONS:

1. Each club that sends LEF approved patients to CPMC can sumbit one reimbursement request per month. Use a second form marked continuation if there are more scheduled patient visits.
2 Each request requires two signatures.
3. Reimbursement is based on the mileage between your club location and San Francisco as obtained from Mapquest, times the approved IRS ***medical*** mileage reimbursement.
   An example is on the reverse side or is attached
4. If the patient is a minor accompanied by an adult, the reimbursement will be 1.5 times that of an adult patient.
5. No request for dates scheduled more than three months old will be honored.
6. To protect patient privacy, do NOT include any medical or other personal information.
7. Mail this form to the address above.

For Accounting use only

Check No _____, Amount $______, Date ________

The Lions Eye Foundation of California-Nevada, Inc. preserves and restores the gift of sight by providing free ophthalmic examinations, operations, and medication to the less fortunate members of our community.