MEDICAL TRANSPORTATION VOUCHER

VOUCHER #

Participant name:________________________ *BRAG Staff Signature:* ____________________

TRIP PURPOSE

Print Date: __________________

☐ Medical Supply ☐ Pharmacy ☐ Cancer Treatment
☐ Medical Appointment ☐ Dialysis Treatment ☐ Critical Nutrition
☐ Other (optional): ____

TRIP DETAILS

Trip date:______________________Trip Time of Day: ______________________

Pick up (full address): ____

Destination (full address): ____

DRIVER INFORMATION (please print clearly)

Driver/company name:____________________________Phone: ____________________

Relationship to participant:____________________Email (optional): ____________________

Street address: ____

City:________________________State:__________________Zip: ____________________

TRIP CALCULATOR (select one)

VOUCHER AMOUNT

Total Miles (1 client):______________________ X $0.40 = [ ]

Total Miles (2+ clients*):____________________ X $0.25 = [ ]

***Note: For 2+ clients in the same vehicle, fill out individual vouchers for each client.**

Driver Signature (above) *Date* *Participant Signature (above)* *Date*

STAFF ONLY: Date Received/Initial:______________ MM Initial/Date:____________ Admin. Initial/Date:____________

Return top portion to agency *Keep bottom for driver receipt*

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VOUCHER #

Participant name:______________________________________

Trip date:____________________________**VOUCHER AMOUNT:** [ ]

Driver Signature (above) *Date* *Participant Signature (above)* *Date*

SAMPLE