



TRANSPORTATION SERVICES

Driver Name: _____ Social Security Number: _____

Address: _____

PERIOD COVERED: _____ To: _____ Authorization Number: _____

Day of Month	Mileage	To / From
1.		
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31.		

TO BE COMPLETED BY DSB STAFF. This certifies that mileage as indicated was provided to a DSB eligible individual. Total Mileage _____ X Rate per Mile \$ _____ = Amount Payable this billing period \$ _____.

Driver Signature: _____ Date: _____

DSB Eligible Individual Signature: Date: _____

DSB VR Counselor Signature: _____ Date: _____