SCCA TRAVEL LOG

HC 32 Box 8174, Truth or Consequences, NM 87901-575-740-3971

Date of Appointment _____

Patients Name_____

Location of Treatment_____ Type of treatment_____

Number of hours for treatment _____

Drivers Name _____Phone_____

Address_____E-Mail_____

I am a licensed New Mexico Driver with Auto Insurance and will **not** hold SCCA liable for an accident which may result in injury of myself or the patient I am transporting. Initial_____

Pick-Up Time_____

Return Time_____ Total Miles Round Trip_____

(Miles from drivers home and return)

Other Passengers in Vehicle (Name) _____Phone_____

Vehicle Used Personal_____ or SCCA _____

Signature of Driver _____ I wish to be Reimbursed ___Yes ___No

Please reimburse Patient because they paid for the gas: Yes_____

Mail check to Patient at: _____

Please return even if you do not want reimbursement within 7 days of your driving.

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