Voluntown Senior Rides Program Request for Mileage Reimbursement

Senior 1		Phone:		
	Passenger Name:	(Please indicate if	trips are <u>ONE</u>	-WAY or ROUND TRIP)
Date	Complete Start Address	Complete Destination Address (include Street #)	*Trip Purpose	Total Miles (Completed by ECTC)
Sample 7/1/15	20 Goldstar Hwy, Groton	L&M Hospital 400 Montauk Ave, New London	Medical Appt.	
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Grant prog	ram allowing eligible passengers to chose in the chose in the chose in the checks or in the check or in the ch	Consortium, Inc (ECTC),), Town of Voluntown are provi their own driver. As such, these drivers are not traine criminal checks been performed. I voluntarily allow thi	d or certified, no	nt of mileage under a Municip
	that I am riding at my own risk. this document, I am fully aware of all provisi	ons stated above and agree to the terms and attest the		ort me in his/her vehicle with f
By signing			above trip inform	ort me in his/her vehicle with f
By signing to	this document, I am fully aware of all provisi Ire (Driver) uthorized:	ons stated above and agree to the terms and attest the Date Signature (Rid	above trip inform	ort me in his/her vehicle with f ation is true:
By signing to	this document, I am fully aware of all provisi	ons stated above and agree to the terms and attest the Date Signature (Rid	above trip inform	ort me in his/her vehicle with f ation is true:
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Signatu Trips au Circle T	this document, I am fully aware of all provisi ure (Driver) uthorized:	Date Signature (Ridesentative) Date	above trip inform	ort me in his/her vehicle with f ation is true:
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