F P D R January 2013	**Bureau of Fire and Police Disability and Retirement** 1800 SW First Avenue, Suite 450, Portland, OR 97201 503-823-6823; FAX – 503-823-5166; B236/450	**REQUEST FOR PRESCRIPTION & MILEAGE REIMBURSEMENT**

MEMBER INFORMATION

☐ **Fire** ☐ **Police**

Member's Legal Name:

Member's Home Address:

Claim No:

Injury Date:

Condition/Illness:

I hereby affirm that the following request for reimbursement is true to the best of my knowledge and belief.

Member's Signature _____ **Date** _____

Important Notice: Pursuant to FPDR Administrative Rules, all requests for reimbursement for expenses paid by the Member must be submitted to and received by the FPDR Director within 60 days of incurring the expense for which reimbursement is sought.

PRESCRIPTIONS

REQUIRED: ORIGINAL PRESCRIPTION LABEL THAT INCLUDES NAME OF PHYSICIAN AND NAME OF MEDICATION & PAYMENT RECEIPT

Date	Medication	Doctor	Cost

FPDR Date Stamp

Total Prescription Cost $_____

MILEAGE

Date	Destination (Name & Address)	Number of Miles

Total Miles _____

(To be completed by FPDR staff: Total Mileage _____X_____¢/mile = $_____)

GRAND TOTAL DUE TO MEMBER $_____