

Medical Appointment Lost Time Reimbursement

Request must be received by FPDR by the end of the pay period

Member Information			
Name (printed)	Email	Phone	
Home address			
City	State	Zip	
<input type="checkbox"/> Fire <input type="checkbox"/> Police	Claim Number	Injury date and time	
Brief description of injury			

Request for missed time from work due to a doctor appointment related to an approved claim.

Appointment Date	Doctor/Provider	Hours
		Total Hours

Applicant's statement: I hereby affirm this request for reimbursement is true and is related to my approved claim. I attest that the time requested is for a documented absence from work.

Signature _____ Print name _____ Date _____

Please sign and mail, fax, or email form to FPDR.

