



# MEDICAL REIMBURSEMENT REQUEST

Return this form, your Medical exam receipt and Driver & Passenger List to: 511 Regional Rideshare Program  
70 Washington Street, Suite 407, Oakland, CA 94607 Please allow 5-6 weeks processing time for your reimbursement.

➤ Please Type or Print in Ink

- Vanpool Driver
- Back-Up Driver

\_\_\_\_\_ Date Van Started: \_\_\_\_\_  
 If Back-Up, Name of Primary Driver \_\_\_\_\_ mo/day/yr

Driver's Name \_\_\_\_\_ Wk # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Of# - \_\_\_\_\_ - \_\_\_\_\_

E-mail \_\_\_\_\_ Employer Name \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Hours: Start \_\_\_\_\_ Stop \_\_\_\_\_ Date of Medical Examination \_\_\_\_\_

Driver's License Number \_\_\_\_\_ State \_\_\_\_\_ Expiration Date \_\_\_\_\_

Social Security Number \_\_\_\_\_ (for identification only, not for tax purposes)

Who owns this van?  Employer Owned  Owner-operated  Buspool  Enterprise  VPSI  
 Size of Van (# of passengers):  11  12  13  14  15 other \_\_\_ Work Hrs \_\_\_ am \_\_\_ pm

- Reimbursement of Medical Payment will be made to: (check only one)
- Driver (if the reimbursement is to be made directly to you)
  - Company or Organization (provide name, address and phone number below)

Company Name \_\_\_\_\_ Send to Attention of: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Company Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Extension \_\_\_\_\_

➤ This claim must be filed within four months after the examination date.

The following items must be included with this application:

- ❖ A copy of the Medical Examiner's Certificate signed by the examining physician
- ❖ A copy of the receipt for this examination: **receipt must indicate DMV exam**
- ❖ A copy of the vanpool medical reimbursement - Participant List

By signing this form I certify the following information

- ❖ That either I or my company/organization has paid for a Department of Transportation Medical Examination to qualify me as a Vanpool Driver under the California Vanpool Program.
- ❖ That this is my first and only application for medical reimbursement. No other application will be submitted hereafter (511 Regional Rideshare Program provides medical reimbursements up to \$75.00, one time only).

➤ Driver's Signature \_\_\_\_\_ Today's Date \_\_\_\_\_

Company Signature \_\_\_\_\_ Today's Date \_\_\_\_\_  
(if applicable)



THIS SECTION IS FOR 511 Regional Rideshare OFFICE USE ONLY

I recommend approval for payment of \$ \_\_\_\_\_ (up to \$75.00) Pool ID \_\_\_\_\_

Authorized Signature \_\_\_\_\_ Approval Date \_\_\_\_\_  
Payment Terms Immediate