



MEDICAL REIMBURSEMENT REQUEST

Return this form, with your Medical exam receipt, Passenger List & Copy of wallet-sized Medical Examiner's Certificate to: 511 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

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

Driver's Name _____ Wk # ____ - ____ - ____ Hm# _____ - ____ - _____

E-mail _____ Date of Birth _____

Home Address _____ City _____ State ____ Zip _____

Employer Name _____

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.

Please include the following with this application:

- ❖ A copy of the Medical Examiner's Certificate signed by the examining physician (green card, front & back)
- ❖ 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 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 RIDESHARE OFFICE USE ONLY

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

Authorized Signature _____ Approval Date _____

Payment Terms Immediate