Drivers License# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ By Submitting this driver log do affirmatively certify I have a current and valid unrestricted driver’s license; that the vehicle used to perform the service listed below has a current and valid annual vehicle inspection sticker and is currently and properly registered and insured pursuant to the laws and regulation of the state of Indiana.

 **I** hereby certify the information contained herein is true, correct and accurate. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Driver)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| TRIP DATE | TRIP CONFIRMATION # | MEDICAL PROVIDER NAME AND PHONE | PHYSICIAN/CLINICIAN SIGNATURE | TOTAL MILES |
|  |  | Name: |  |  |
| Phone: |
|  |  | Name: |  |  |
| Phone: |
|  |  | Name: |  |  |
| Phone: |
|  |  | Name: |  |  |
| Phone: |
|  |  | Name: |  |  |
| Phone: |
|  |  | Name: |  |  |
| Phone: |
|  |  | Name: |  |  |
| Phone: |

\*Trips listed in this driver log are required to be approved by LogistiCare prior to the date of service. The required signature listed on this log must be a representative from the medical provider. The reimbursement rates for the trips listed are ..**36 per loaded mile**. Please submit the completed driver log to the address listed above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Official use, do not write below this line\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_