Workers' Compensation Board
Alberta

C660
TRAVEL REIMBURSEMENT

Box 2415, Edmonton
Alberta T5J 2S5
Fax 780-427-5863
1-800-661-1993

Please print clearly / or type

Claim Number

Personal Health Number

Client's *Surname* *First Name* *Initial*

Address *Street* *City/Town* *Province* Postal Code

Telephone Number Date of Accident *(Year / Month / Day)* Date of Birth *(Year / Month / Day)*

To be completed by Client

Travel expenses cannot be claimed for picking up batteries

From: _____ *(City / Town)* To: _____ *(City / Town)*

This trip was for the sole purpose of obtaining service for my hearing aid(s).

(Signature of WCB Client) Date *(Year / Month / Day)*

To be completed by Service Provider

Appointment Time Appointment Date *(Year / Month / Day)*

Services Rendered

Name and address of Service Provider: (please print)

Service Provider Signature:

Print Name:

Date *(Year / Month / Day)* Telephone Number

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.

DES: Date of Appointment