



Wisconsin's Self-Directed Supports Program

Mileage Log

Pay Period End Date: ___ ___ / ___ ___ / 20 ___ ___ Employee Number: _____

Employee Name (please print): _____

Participant Name (please print): _____

Date	To	From	Purpose / Description	Miles
DO NOT USE THIS FORM FOR MEDICAL TRANSPORTATION				
			Total Miles	

Employee Signature: _____ Date: _____

Participant Signature: _____ Date: _____