**Senior Rides Program**
**Request for Mileage Reimbursement**

**Driver Name:** _____
**Driver Address:** _____ **Tel. :** _____

**Senior Passenger Name:** _____*(Please indicate if trips are ONE-WAY or ROUND TRIP)*

| Date | Complete Start Address | Complete Destination Address (include Street #) | *Trip Purpose | *One Way or Round Trip* | *Total Miles (Completed by ECTC)* |
|---|---|---|---|---|---|
| Sample *7/1/07* | *20 Goldstar Hwy, Groton* | *L&M Hospital 400 Montauk Ave, New London* | *Medical Appt.* | | |
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***Trip purpose must be medical trips only.** **Return form to your senior center for review and they will forward the form to ECTC by fax.**

**I as a passenger or driver understand by signing this document that I am releasing the Eastern Connecticut Transportation Consortium, Inc (ECTC), Town of Groton, Town of Waterford, Town of East Lyme and City of New London from any responsibility of any type of vehicle damage, injury and/or death caused by an accident during the voluntary transport for this program.**

**I understand that Eastern Connecticut Transportation Consortium, Inc (ECTC), Town of Groton, Town of Waterford, Town of East Lyme and City of New London, are providing reimbursement of mileage only under the Municipal Grant program and do not participate in the eligible passenger's choice of driver or vehicle. As such, these drivers are not trained or certified, nor have any checks such as safety inspections, verification of insurance, license checks or criminal checks been performed. I voluntarily allow this driver to transport me in his/her vehicle with full knowledge that I am riding at my own risk.**

**By signing this document, I am fully aware of all provisions stated above and agree to the terms and attest the above trip information is true:**

_____ _____ _____ _____
**Signature (Driver)** **Date** **Signature (Rider)** **Date**

**Trips authorized:** _____ _____
**Signature (Senior Center Representative)** **Date**

**Circle Town Affiliation:** ***Groton*** ***Waterford*** ***East Lyme*** ***New London*** ***Stonington***

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## (FOR ECTC OFFICE USE ONLY)

_____ x _____= _____
Rate x Total miles **Reimbursement Cost**

**Total Medical Trips:** _____