

N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES DIVISION OF SERVICES FOR THE BLIND VOCATIONAL REHABILITATION

TRANSPORTATION SERVICES

Driver Name:		Social Security Number:	
Address:			
PERIOD COVERED:		To:	Authorization Number:
Day of Month	Mileage		To / From
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31.			
TO BE COMPLETEI individual. Total Mile	D BY DSB STAFF ageX F	This certifies that Rate per Mile \$	mileage as indicated was provided to a DSB eligible = Amount Payable this billing period \$
Driver Signature:			Date:
	Г		
DSB Eligible Individual Signature:			Date:
DSB VR Counselor Signature:			Date:
D 4050 V/D Is sure of 00/00	Devide and 40/00 (4 - 5 4)	