PLEASE PRINT

MEDICAID - DIRECT SERVICE CLAIMS
TRANSPORTATION LOG

BUS DRIVER:_____ **PHONE:**_____ **SCHOOL DISTRICT:**_____

Circle Appropriate Month → July Aug Sept Oct Nov Dec Jan Feb Mar Apr May June

Student Information (Last Name, First Name)	BUS #	W/C	Rounded 1-way Miles		M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F
Name:				AM																				
				PM																				
Name:				AM																				
				PM																				
Name:				AM																				
				PM																				
Name:				AM																				
				PM																				
Name:				AM																				
				PM																				
Name:				AM																				
				PM																				
Name:				AM																				
				PM																				
Name:				AM																				
				PM																				
Name:				AM																				
				PM																				
Name:				AM																				
				PM																				
Name:				AM																				
				PM																				
Name:				AM																				
				PM																				
Name:				AM																				
				PM																				
Name:				AM																				
				PM																				
Name:				AM																				
				PM																				
Name:				AM																				
				PM																				

I certify that this information is accurate.

DRIVERS SIGNATURE:_____ **DATE:**_____