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| **National Health Service Retirement Fellowship****Weymouth Community Hospital****Melcombe Avenue****Weymouth DT4 7TB****Tel: 01305 361317****Kay.Robinson@.nhs.net** |  | **Central Office**  **Expenses Claim Form** |

Name: ……………………………………………………………… Address: ………………………………………………………………………….

……………………………………………………………………………………………………………… Post Code: ……………………….

## Signature: ………………………………………………………………… Date: ………………………….

## Completion of Expenses Claim Form

## Please use a separate line for travel expenses, for subsistence and for other expenses

All claims must be sent to Central Office by the 7th of the month for authorisation by the DO / Chief Executive (see Expenses Guidelines)

The form must be signed by the claimant to confirm that the claims are in connection with Fellowship business and the expenses have been necessarily incurred.

Receipts should be attached to the claim form with a paperclip (please do not use staples)

Mileages can be determined by trip or mileometer readings or through an on-line route planner e.g. [www.viamichelin.com](http://www.viamichelin.com), www.google.com/maps

The two right hand columns of the expenses table are for Central Office use.

Payments are made by bank transfer; please make sure that Central Office have your bank details; if this is your first bank transfer please complete the box below.

|  |
| --- |
| Account Name:………………………………………………………….. Sort Code: ………………………………………………..Account Number: ………………………………………………………. |

**01.04.2019**

Miles from 1 April b/f…………………… Miles this claim………………………….. Miles carried forward……………………

Miles from 1 April b/f…………………… Miles this claim………………………….. Miles carried forward……………………

Miles from 1 April b/f…………………… Miles this claim………………………….. Miles carried forward……………………

Miles from 1 April b/f…………………… Miles this claim………………………….. Miles carried forward……………………

**Name……………………………………………..**

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|  **Date** | **Details of journey** | **Depart/ Arrive** | **Nature of Business / Specific expenditure** | **Total Car Miles** | **Passenger Miles** | **Fares** | Subsistence | Other | **Office Use (Code)** | **Office Use****Total** |
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|  | **Stationery/ Photocopies** |  |  |  |  |
|  | **Telephone** |  |  |  |  |
|  | **Postage** |  |  |  |  |
| Total Payable |  |

**Please ensure that you have completed both sides of this claim form**.

Date Paid: ………………………………… CAF Ref: …………………………………. Signed : ……………..………………………… (DO / CEO)