MEDICAL EXPENSES CLAIM FORM

NAME OF STAFF MEMBER: _____

PAYROLL NO: _____ **SALARY LEVEL:** _____

EMPLOYMENT STATUS: _____ *(**N.B.** Must be permanent officer or daily rated worker or no entitlement exists)*

POST TITLE: _____ **POST NUMBER:** _____

MINISTRY: _____ **DEPARTMENT:** _____

(To be used by permanent officers only – Members of daily rated workers families are not entitled to re-imbursement)

NAME OF THE PERSON RECEIVING TREATMENT, IF NOT THE OFFICER: _____

RELATIONSHIP TO THE OFFICER _____

FULL DETAILS OF MEDICAL EXPENSES BEING CLAIMED – INCLUDE NAME AND LOCATION OF HOSPITAL(S) AND OTHER PLACES OF TREATMENT, A LIST OF MEDICINE (ATTACH MEDICAL CERTIFICATE IF PRIVATE)	**TOTAL AMOUNT PAID IN VT**
(SEE ATTACHED ORIGINAL RECEIPTS) TOTAL AMOUNT PAID OUT VT	

CLAIMING STAFF MEMBER'S CERTIFICATION

I certify that I have necessarily incurred and paid for the above medical treatment, that I have attached original receipts and that I now wish to claim reimbursement from the Government.

NAME: _____ **SIGNATURE:** _____

Date: _____

DIRECTOR/DIRECTOR-GENERALCERTIFICATION

I certify that the above information is correct and that he/she is a permanent officer or daily rated worker (*circle whichever is correct)* employed in my Department/Ministry on the above salary level.

NAME: _____ **SIGNATURE:** _____

DATE: _____

DEBIT TO CHAPTER HEAD: _____

SECRETARY OF OPSCS CERTIFICATION

I certify the personal details of the officer/daily rated worker are correct and that the person receiving treatment is entitled to reimbursement in accordance with the *Staff Manual.*

NAME: _____ **SIGNATURE:** _____

DATE: _____

Staff member and Department of Finance advised on: _____