

Invoice/claim number: _____



SOUTH WESTERN SYDNEY AREA HEALTH SERVICE

CONSUMER, CARER & COMMUNITY REPRESENTATIVES CLAIM FOR REIMBURSEMENT

Name:

Address:

Phone Number:

Consumer Group/Advisory Committee and area/sector:
(if appropriate)

TRAVEL REIMBURSEMENT				
Vehicle engine size: over 1600/under 1600 cc (cross out whichever not applicable)				
From	To	Purpose of Journey	Kms	Date

Details of other reimbursements (receipts required):
.....
.....

Participant/Representative's Signature: Date:

OFFICE USE		
(Rate: over 1600cc – 31.4c per k; under 1600cc – 26.3c per k)		
Total Kms =	@	= Total:
Other reimbursement		= Total:
		Total Claim:
Certified correct in terms of Section 7.20 of the Accounts and Audit Determination: :		Date:
Authorised in terms of 7.22 of the Accounts and Audit Determination:		Date:
Cost Centre :	Account Code:	Amount:
Cost Centre :	Account Code:	Amount: