HOSPITAL SITE / BASE:

……..

VOLUNTEER / MEMBERS TRAVEL AND SUBSISTENCE CLAIM
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST

FIRST NAME…..…….. .

SURNAME ……..

CONTACT PHONE NUMBER ……

MEMBER / VOLUNTEER (delete as applicable)

VOLUNTEER / MEMBER BANK DETAILS – REIMBURSEMENT WILL BE SENT VIA BACS TO THIS ACCOUNT: (PLEASE NOTE, IF WE ALREADY HAVE YOUR DETAILS YOU DO NOT NEED TO ENTER THEM HERE)

*** BANK NAME / ADDRESS**: ……..

*** SORT CODE**: ☐☐-☐☐-☐☐ * **ACCOUNT NUMBER**: ……..

* **ACCOUNT NAME:**……

NB – Any crossings out / amendments must be signed against. Failure to do so will result in payment being delayed

HOME ADDRESS

……

……

…… POSTCODE ……

AREA OF WORK : …….. MAKE OF CAR ……..CC ……

MONTH OF CLAIM : ……..20 … VEHICLE REG …….

SUBMISSION OF THIS CLAIM IMPLIES THAT YOUR VEHICLE IS BEING MAINTAINED IN A ROADWORTHY CONDITION MILEAGE WILL BE REIMBURSED

Email Address:……

I CERTIFY THAT:

1 The travelling expenses and subsistence allowances claimed and detailed overleaf are in respect of journeys actually and necessarily incurred whilst engaged on the business stated.

2 Where a claim for mileage allowance is made:

A. the journeys detailed on this expenses claim form were undertaken in the vehicle of make cc and registration shown and were necessarily incurred by me on the business of the Trust.
B. the insurance policy in respect of this vehicle is currently in force and provides cover while the vehicle is used on the official business of the Trust including the journeys overleaf for full third party insurance risk or injury to or death of passengers and damage to property.

3 Where a claim for a day subsistence allowance has been made it was necessary to spend more on meals than is incurred when at my normal base and that where a claim for over 8 hours is submitted I have necessarily incurred expenditure on an additional meal.

VOLUNTEER / MEMBER SIGNATURE.....DATE……

DEPT MANAGER/SUPERVISOR SIGNATURE…… DATE……

I DECLARE THAT:
The expenses claimed were authorised necessary and on official business and that where claims have been made against receipts; these have been scrutinised and are attached. All addition / calculations have been checked.

SIGNATURE OF AUTHORISING OFFICER …… …… IN BLOCK LETTERS …… DATE ……
(This must be business unit manager / support manager)

COST CENTRE / EXPENSE CODE AGAINST WHICH CLAIM IS TO BE PAID: _ _ _ _ _ / _ _ _ _ _ Total to be paid (detailed over) : £……

COMPLETED CLAIMS TO BE SENT TO : ACCOUNTS PAYABLE, FINANCE DEPT, LINCOLN COUNTY HOSPITAL

VOLUNTEER TRAVEL AND SUBSISTENCE CLAIM FORM

DATE	DETAILS OF JOURNEY		Car Mileage reimbursed @ 0.40ppm			BUS/RAIL FARES/TOLLS		SUBSISTENCE				TOTAL
	Purpose of journey	Starting point ALL places visited and finishing point		AMOUNT				TIMES		AMOUNT		
			Mileage	£	P	£	P	From	To	£	p	£
	Grand Total											