New Zealand Hospital Pharmacy Association (Inc)

Te Kāhui Whakarite Rongoā Hōhipera o Aotearoa

EXPENSE CLAIM FORM

Name: _____ **Date:** _____

Address: _____

_____

Email Address: _____

Claim for: *(Please tick)*

☐ **Executive** (000) ☐ **Technician SIG** (TEC) ☐ **Mental Health SIG** (MTH)

☐ **CNO SIG** (CNO) ☐ **MICP SIG** (MIC) ☐ **Hospital Pharmacy Managers** (HPM)

☐ **Roche Award** (RCC) ☐ **Education Fund Award** (EDF)

☐ **Other (please state)** _____

Date	Supplier	Description of goods or activity/who present/details or reason for purchase	GST	Amount (incl GST)
Please attach tax invoices to support your claim or if claiming reimbursement for an award granted by the Executive please attach a copy of your confirmation letter				
TOTAL CLAIM				

Bank Account No:	

The above expenses were incurred on behalf of the New Zealand Hospital Pharmacy Association (Inc) by myself.

Award claims: I declare that the funding applied for and received from NZHPA has not been claimed from other sources.

Signed (Claimant): _____ **Date:** _____

Administration Verification _____ **Date** _____