New Zealand Hospital Pharmacy Association (Inc)

Te Kāhui Whakarite Rongoā Hōhipera o Aotearoa

TRAVEL/ACCOMMODATION BOOKING FORM
(Domestic Flights only)

Name: _____

Full Name: _____

(as per identification i.e. passport)

Email Address: _____ Cellphone: _____

Organisation: _____

NZHPA Member No: _____

Reason for travel: _____

Meeting start time: _____ Expected finish time: _____

Air Travel Required: Yes / No

Will you have? Carry on only: Yes / No Checked Bags: Yes / No

Airpoints scheme & no. (if applicable):_____ ❑ One Way ❑ Return

Departing Flight

Departing City: _____

Arrival City: _____

Date: _____ Pref. Time.: _____

Preferred Airline and Flight no.: _____

Returning Flight

Departing City: _____

Arrival City: _____

Date: _____ Pref. Time.: _____

Preferred Airline and Flight no.: _____

Any Special Requirements: _____

Travel requested/approved by: _____

*Note: Should you have to amend your flight time or cancel your travel at late notice due to personal reasons you **may** be required to reimburse the New Zealand Hospital Pharmacy Association for costs incurred.*

Accommodation Required: Yes / No

Name and address of Hotel: _____

Date in: _____ Date out:_____

Twin share: Y / N Sharing with: _____

Additional Comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

For office use only		
Date Actioned	Person Actioned	Flight Costs