



New Zealand Hospital Pharmacy Association (Inc)

Te Kāhui Whakarite Rongoā Hōhipera o Aotearoa

EXPENSE CLAIM FORM

Name: _____ Date: _____

Address: _____

Email Address: _____

- Claim for: ☐ Executive (000) ☐ Technician SIG (TEC) ☐ Mental Health SIG (MTH)
(Please tick) ☐ Cancer Care SIG (CC) ☐ MICP SIG (MIC) ☐ Hospital Pharmacy Managers (HPM)
☐ 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 _____

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