

MEDICAL EXPENSES REFUND

To be filled in Duplicate. Original receipts and other supporting documents must be attached

DATE _____

SECTION A

Staff details

FROM _____ PF No. _____
(Name of Staff)

DEPARTMENT _____ DESIGNATION _____

NAME OF BANK _____ BRANCH _____

ACCOUNT NUMBER _____

TO: FINANCE OFFICER

Thro'
HOD/DEAN/DIRECTOR _____ SIGN _____
(Name of Authorizing Officer)

SECTION B

Refund details

Please arrange to refund Kshs _____ (Read Kenya Shillings _____
(Amount in figures) (Amount in words)

_____)
being money I spent as Consultation fees/ Laboratory charges/ X-Ray expenses/ Drugs purchase/ Optical costs/
Dental treatment charges.. etc for _____

(Name of Patient)
who is my _____ and is listed as my legal dependant at the College Health Services.
(Relation to Staff)

CLAIMANT SIGNATURE _____
(Signature of Staff)

SECTION C

Official Use

Pharmacist's comments _____

Pharmacist's Signature _____ Date _____

APPROVED NOT APPROVED (Tick as appropriate)

Medical Officer's Signature _____ Date _____