UNIVERSITY OF EDUCATION, WINNEBA

R01 - CLAIM FORM FOR MEDICAL EXPENSES REFUND

Part A - Details of Claimant

Name: _____ Designation: _____

Staff Number: _____ Telephone Number: _____

Faculty/Department/Section/Unit: _____ Month/Year: _____

Part B - Details of Claim

Please tick the relevant medical item below and write the corresponding amount of refund requested.		
Please tick	**Item**	**Cost (GH¢)**
	Consultation	
	Drugs	
	Surgery	
	Physical Examination	
	X-Rays, CT Scans and MRIs	
	Electrocardiography (ECG)	
	Laboratory Tests	
	Inpatient Accommodation	
	Other (Please specify):	
Total		

Claimant's Declaration:

I certify that the above medical expense(s) was/were incurred by me in respect of myself/ husband/ wife/ child(ren)/ wards. Relevant prescription forms and receipts are attached.

_____ _____

Signature of Claimant **Date (DD/MM/YYYY)**

Part C - Approving Officers

_____ _____

Director, Health Services **Date (DD/MM/YYYY)**

_____ _____

Deputy Registrar, Human Resource **Date (DD/MM/YYYY)**

_____ _____

Registrar **Date (DD/MM/YYYY)**

Part D - Authorising Officer

_____ _____

Finance Officer **Date (DD/MM/YYYY)**

Part E - Claim Summary *(For Accounts Officer's Use Only)*

Total amount due to Claimant: GH¢ _____

_____ _____ _____

Prepared by **Signature** **Date(DD/MM/YYYY)**

_____ _____ _____

Checked by **Signature** **Date(DD/MM/YYYY)**

This Form has been designed in accordance with Section 15.2.1 of the University's Financial and Stores Regulations. It is to be used only for the claim for which it is meant