LV | LOCUM VISION
MEDICAL RECRUITMENT

EXPENSE FORM

AGENCY WORKER NAME		WEEK ENDING DATE	/ /
SPECIALITY		GRADE	
HOSPITAL NAME		DEPARTMENT / WARD	

ACCOMODATION

Date	Company name	Nights stayed	Receipt value	VAT Receipt provided?	Expense paid by? Please Circle
01/01/2018	Premier Inn	01/01/2018 – 02/01/2018 (2 nights)	£100	Yes / No	Locum Vision / Hospital?
				Yes / No	Locum Vision / Hospital?
				Yes / No	Locum Vision / Hospital?
				Yes / No	Locum Vision / Hospital?
				Yes / No	Locum Vision / Hospital?
				Yes / No	Locum Vision / Hospital?
				Yes / No	Locum Vision / Hospital?
				Yes / No	Locum Vision / Hospital?
				Yes / No	Locum Vision / Hospital?

TRAVEL

Date	Journey From (postcode)	Destination (postcode)	Reason for travel	Total Miles	Expense paid by?
01/01/2018	RM34 8AB	MK23 9AB	Hospital Cross site cover	40	Locum Vision / Hospital?
					Locum Vision / Hospital?
					Locum Vision / Hospital?
					Locum Vision / Hospital?
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					Locum Vision / Hospital?
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					Locum Vision / Hospital?

Please send all VAT receipts with this form for all expense claims. Any claims made without a receipt will not be processed. Any expenses not agreed within your initial contract will not be paid. Please send all expense claims to timesheets@locumvision.com

GETTING THE EXPENSE FORM AUTHORISED IS THE AGENCY WORKERS RESPONSIBILITY.

TO BE COMPLETED BY THE AGENCY WORKER

☐ By ticking this box I confirm that I have received approval for the above expenses.

"I declare that the infomartion i have given on this form is correct and that i have not claimed elsewhere for the expenses detailed on this form. I understand that if i knowingly provide false information this may result in disciplinary action and i may be liable to prosecaution and civil recovery proceedings. I consent to the discloser of infomation from this form to and by the NHS Body and the NHS Counter Fraud and Secroty Management Service of the purpose of verification of ths claim and the investifgation, preventipon, detection and presecution of fraud. I confirm that i have been inducted in line with the trust local procedures and that i have been made aware of given all relevant access to my Day 1 rights". If the recepits are not provided your expenses will not be paid.

PRINT NAME: _____ SIGNATURE: _____ DATE: _____

TO BE COMPLETED BY THE HOSPITAL / LOCUM VISION REPRESENTATIVE

"I am an authorised signatory of my ward/department/NHS Body. I am signing to confirm that the above expenses that I am authorising are accurate and I approve for payment. I understand that if I knowingly authorise false information this may result in disciplinary action and I may be liable for prosecution and civil recovery proceedings. I consent to the discloser of information from this form to and by the NHS Body and the NHS Counter Fraud and Security Management Service for the purpose of verification of this claim and the investigation, detection and prosecution of fraud".

PRINT NAME: _____ JOB TITLE: _____

SIGNATURE: _____ DATE: _____

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