University of Eldoret
flame of knowledge and innovation

UOE/MEDI/01/002

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 _____

OFFICE OF THE DEPUTY VICE CHANCELLOR (Administration, Planning & Finance) [QA-002©2013]