|  |  |  |
| --- | --- | --- |
|  |  | INVOICE |

**This form must be TYPED and COMPLETED in FULL, failure to do this will result in a delay or NON PAYMENT** (LETB use only)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Title |  | GMC No. |  |  |  | Invoice Number |  |
| First Name  (In Full) |  | | |  |  | Invoice Date | / / |
| Middle Initial  (In Full) |  | | |  |  | PO Number | **XXGSAMS** |
| Surname |  | | |  |  | Code | ASZ /7300/T /M |
| Address Line 1 |  | | |  |  |  |  |
| Address Line 2 |  | | |  |  |  |  |
| Address Line 3 |  | | |  |  |  |  |
| Town/City |  | | |  |  |  |  |
| Post Code |  | | |  |  |  |  |

|  |
| --- |
| Invoice To:  **NHS ENGLAND**  **X24 PAYABLES K005**  **PO BOX 312**  **LEEDS**  **LS11 1HP** |
| **Return To:**  [gpfinance.sw@hee.nhs.uk](mailto:gpfinance.sw@hee.nhs.uk) |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Bank Account Number | | | | | | | | Bank Account Sort Code | | | | | | bank account name | Swift code  (overseas only) | E-mail address for  remittance advice |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |

**PLEASE ENSURE BANK DETAILS ARE ENTERED. FAILURE TO ENTER THESE DETAILS WILL RESULT IN PAYMENT DELAYS.**

|  |  |
| --- | --- |
| **Total Value of the Claim** | **£** |

Please complete the breakdown of the claim on the following page

**Details of the Claim**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Expenses | |  | |  |
| Details of Journey –  *(start-> to -> finish)* | | |  |  |
| Public Transport | **Mode of transport: \_\_**  *(Receipts must be attached)* | | | **£** |
| **Private Transport** | **Total Number of Miles: \_@ 45p per mile**  *(Mileage will be calculated at shortest route)* | | | **£** |
| ***Passengers***  *(Reimbursed at 5p per mile per passenger)* | **Name(s) of passenger(s): \_\_\_\_**  **Total miles travelled with passenger \_**  *(Passengers must be travelling to the same event & also entitled to reimbursement of travel expenses)* | | | **£** |
| Subsistence | *Accommodation Expenditure* | | | **£** |
| *Meal Expenditure* | | | **£** |
| Other Expenses  *Please specify:-* |  | | | **£** |
|  | TOTAL AMOUNT OF CLAIM | | | £ |

|  |  |  |
| --- | --- | --- |
| **DETAILS OF CLAIM (ALL CLAIMS MUST BE ACCOMPANIED BY RECEIPTS)**  Please read the guidance notes you obtained along with this claim form very carefully.  Where there is no receipt a written explanation must be attached and payment will at the discretion of Health Education South West.  Health Education England reserves the right to reimburse the cheapest option wherever relevant. | | |
| EVENT/ACTIVITY |  | |
| LOCATION |  | |
| DATE(S) | From: | To: |

**Original receipts should accompany every claim form to verify the authenticity of all expenditure detailed upon it. Claims should be submitted within six weeks of the event taking place and absolutely no later than three months.**

|  |
| --- |
| **Claimant Declaration: I declare that the expenses claimed hereunder were necessarily incurred by me in attending the above event and are in accordance with the conditions governing the payment of travelling expenses attached. I understand that any fees are paid gross and that I am responsible, where appropriate, for declaring this income for tax purposes.**  **Signed: Date:** |

**Certification of Attendance: I have checked this claim and am satisfied that the claimant attended the event according to the information given and that the Total claimed is correct.**

**Name:**

**Signed: Date:**

**Please send the completed form to :-**

[gpfinance.sw@hee.nhs.uk](mailto:gpfinance.sw@hee.nhs.uk)

|  |
| --- |
| **Authorised By**  **Name : Contact Number:**  **Signed : Date:** |