UNIVERSITI PENDIDIKAN SULTAN IDRIS SULTAN IDRIS EDUCATION UNIVERSITY	**STAFF MEDICAL REIMBURSEMENT CLAIM FORM FOR GOVERMENT CLINICS/HOSPITALS** **STAFF WELLFARE UNIT, HUMAN RESOURCES DIVISION** **(TEL. NO: 05-4506344/6440 NO. FAX: 05-4595488)**

CLAIM TERMS AND CONDITIONS

1 Staff has paid for own treatment expenses at government clinics/hospitals.
2 Patient: Staff, Spouse, Children and Parents.
3 Claims must be made within a period not exceeding 90 days (3 months) from the date of receipt / invoice in the current year.
4 The completed form must be submitted to the Staff Welfare Unit, BSM and the following documents should be attached to the treatment receipt / invoice.

STAFF INFORMATION

NAME :
POSITION/GRADE :
STAFF NO. : PHONE NO.
DEPARTMENT :

PATIENT INFORMATION

NAME :
RELATIONSHIP :
NAME OF HOSPITAL/CLINIC :
REASON FOR TREATMENT :
RECEIPT/INVOICE NO. : DATE OF RECEIPT/INVOICE:
CLAIM AMOUNT (RM) :

VERIFICATION

I hereby confirm all the information and supporting documents given pertaining to this application are true

Information	Staff	Verified by Head of Department	Checked and Verified by Staff Wellfare Unit
Signature			
Position and Official Stamp Date			

FOR HUMAN RESOURCE DIVISION'S REFERENCES

CLAIM APPLICATION : ☐ Approved

☐ Not approved (reason):

_____

_____

_____

Signature of Human Resource Division's Head Of Department : _____

Name and Official Position Stamp :

_____

Date : _____

Kindly attach the original receipt here. If the space provided is not enough, do use a separate attachment.