Please use Adobe Reader or Acrobat to fill this form

Hint

eahp european association of hospital pharmacists — making the difference in medication

Expenses Claim Form

CLAIMANT *I declare that the expenses incurred below were paid by me personally and hereby request reimbursement by the EAHP.*

NAME:

ADDRESS:

POSTCODE: CITY: COUNTRY:

EMAIL: PHONE:

REASON FOR CLAIM: EAHP MEETING/EVENT/OTHER [please give details]:

Name of the event:

Date: Venue:

Number of days to be reimbursed via hospital contract (not including weekends): days

Expenses

Original receipts must be attached for each item claimed and send in originals to **eahp- Boulevard Brand Whitlock 87, Box 11 (4th floor) – 1200 Brussels – Belgium.**

Item	Date	Description of goods & services / Name of provider	Non EU currency	Amount in €
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

			Receipt Value
		Total in Euro	0.00
I declare		km at 0.3653 €/km	0.00
I declare		Days at 20 € only for travelling days	0.00
		TOTAL TO BE REIMBURSED[1]	**0.00**

Payment by bank transfer to:

Bank:		Account Holder:	
Address:		SWIFT (BIC) Code:	
		IBAN (Acc number)	

Date: Signature:

Print