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|  |  | 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 |  |  |  | Invoice Number | SWDD/VT/ |
| First Name  (In Full) |  |  |  | Invoice Date | / /201 |
| Middle Initial  (In Full) |  |  |  | PO Number | **XX KWilliams** |
| Surname |  |  |  | Code | ASM / /T2800/M5018 |
| Address Line 1 |  |  |  |  |  |
| Address Line 2 |  |  |  |  |  |
| Address Line 3 |  |  |  |  |  |
| Town/City |  |  |  |  |  |
| Post Code |  |  |  |  |  |

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| --- |
| Invoice To:  **Health Education England – T73**  South West LETB  **T73 Payables F485**  Phoenix House  Topcliffe Lane  Wakefield  WF3 1WE |
| **Return To:**  Department of Postgraduate Dental Education  Vantage Office Park  Old Gloucester Road  Hambrook  Bristol BS16 1GW |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **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: \_@ 24p per mile**  *(Mileage will be calculated at shortest route)* | | | **£** |
| ***Passengers***  *(Reimbursed at 2p 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 South West reserves the right to reimburse the cheapest option wherever relevant. | | |
| EVENT/ACTIVITY |  | |
| LOCATION |  | |
| DATE(S) | From: | To: |

|  |
| --- |
| **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:** |

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

Department of Postgraduate Dental Education

Vantage Office Park

Old Gloucester Road

Hambrook

Bristol BS16 1GW

|  |
| --- |
| **Authorised By**  **Name : Matthew Hill Contact Number: 01454 252672**  **Signed : Date:** |