Te Whatu Ora
Health New Zealand
Te Tai Tokerau

POSTGRADUATE NURSING PROGRAMME CLAIM FORM

CHECK LIST
*(Please provide receipts and claim cost **up to** the amount recorded in the trainee's contract)*

Attach:

Copy of results ☐

GST receipts ☐

Organisations GST invoice for costs (external only) ☐

Send to: PG Nursing Coordinator
Email: PGNursing@northlanddhb.org.nz
Post Rm 35, Nursing & Midwifery Directorate, Maunu House
Te Whatu Ora Tai Tokerau, Private Bag 9742, Whangarei 0148

STAFF INFORMATION	
Staff Members Name:	
Name of Organisation:	
Course / Papers completed:	
Semester and year:	
Study Days (include all dates related to study blocks) ie. Block One; 17th, 18th Jan	

CONTRACTED ALLOCATION (enter as per contract)	
Fees	$
Travel/Accommodation	$
Clinical Release	
TOTAL	

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ACCOMMODATION (*attach GST receipts*)		
Block	**Details**	**Amount**
		$
		$
		$
TOTAL		**$**

TRAVEL COSTS	
Te Whatu Ora car utilised? (*Te Whatu Ora Staff only*)	Yes / No
Extra travel costs (*other than mileage, ie parking/tolls - attach GST receipts)*	$
Flights *(attach payment information)*	$
Mileage *(use table below if private vehicle used)*	$
TOTALS	$

PRIVATE / WORK VEHICLE USE TABLE		***NB: Te Whatu Ora Staff can claim IRD Mileage rate - $1.04c/km External organisations claim km as per organisational policy***
DATE TRAVELLED	FROM / TO	NO. OF KM TRAVELLED
TOTAL		
OFFICE USE ONLY		

CLINICAL RELEASE/STUDY LEAVE/SUPERVISION COSTS *(external organisations only)*	
Clinical Release/Study Leave costs	$
Clinical Supervision: eg. prescribing practicum	$

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AUTHORISATION / SIGNATURES	
Trainee	Date
Line Manager *(confirm study days were attended as stated)*	Date
Nurse Coordinator: Post Graduate Education	Date
Chief Nurse	Date
Business Analyst	Date

OFFICE USE ONLY

COST CODE	AMT CLAIMED	AMT REIMBURSED
5015215-2205-00071 (fees)	$	$
5015215-2205-00071 (clinical release)	$	$
5015215-2205-00071 (supervision)	$	$
5015215-2205-00071 (travel)	$	$
5015215-2205-00071 (accom)	$	$
GST	**$**	**$**
TOTAL	**$**	**$**

STAFF EXPENSES/CME REIMBURSEMENT FORM

Name_____ Department _____

Employee No _____ ☐ **W** ☐ **R** Phone_____ Cost Code 5015215-2205-00071

Reason for Expenses Incurred/Course/Meeting: _____

PROVIDE DESCRIPTION FOR ITEMS CLAIMED	Claim $	Payroll Element	
TRAINING: Course fees, Conferences and Study Grants *(suffix 00072)*		CME Y=C HWF Y=H	GST N=X
Courses/Conferences Fees:		RCON	G
Flights (CME & RMO)		RFLI	G
Accommodation:		RACOM	G
Travel:		RTRAV	G
Course Materials:		RCMAT	G
Meals:		RMEAL	G
Tertiary Study/Training Fees:		RTSTUD	G
Technology:		RTECH	G
Journals and Texts:		RJNL	G
Professional Membership Fees and Costs *(suffix 00076)*			
Membership Fees/Subscriptions:		RMFEE	G
Practice Insurance Premiums:		RINS	G
Annual Practicing Certificates:		RPRAC	G
BUSINESS EXPENSES (meetings etc.)			
Accommodation *(5260):*		RACOM B	G
Flights (*5250*)		RFLI B	G
Travel/Mileage*(5250/5255):*		RTRAV B	G
Meals *(5260):*		RMEAL B	G
Other *(relocation, uniforms, telephone etc.)*			
Details:			G
			G
			G
Is this a CME (Continuing Medical Education) claim? ☐ Yes ☐ No % ____		**Total Claim $NZ**	
Is this a HWF (Health Work Force - CTA) claim? ☐ Yes ☐ No		**Other Currency**	

SMOs: I declare that my only income from Medical Practice is derived from employment by Te Whatu Ora – Health NZ
Signature: **Date** / /

Flight details (if multiple trips and flights please provide details separately):

Date:____Departure: _____(Final) Destination _____ ☐ single ☐ return ☐ Economy ☐ Prem. ☐ Business

Date:____Departure: _____(Final) Destination _____ ☐ single ☐ return ☐ Economy ☐ Prem. ☐ Business

Claimants Signature: _____ Date __ /____/

Controlling Officer: _____ Date __ /____/
Signature name

Business Analyst: _____ Date __ /____/
Signature name

General Manager: _____ Date __ /____/
Signature name