DAUGHTERS OF CHARITY SERVICE, LIMERICK

Claim Form for Accommodation / Travel Allowance
Student Nurses Intellectual Disability Degree Programme Unrostered Placement

Name:		**Address for Payment**	
Cohort:			
Payee No:			
Student No:			

Accommodation Allowance				Office Use Only
Date from:	Date To:	Placement	Claim Amount	Amount Due
		Total Accommodation		

Travel Allowance						Office Use Only
Date from:	Date To:	Placement	Bus	Other	Claim Amount	Amount Due
				Total Travel		
				Overall Total		

Claimant:
I confirm that the above has been undertaken by me during my Clinical Placement.

From:		**To:**		**And my normal place of residence is correct**

Signed:		**Date:**	

Please attach all receipts
Claim Form must be submitted with attendance forms within two weeks of completion of block of Clinical Placement

Certifying Officer:
I have examined the claim submitted and certify that they are in order for payment

Signed:		**Date:**	