EXPENSE CLAIM

ST JOHN AMBULANCE AUSTRALIA (NSW)

NAME _____ DATE _____

POSITION _____

KILOMETRES

DATE	FROM	TO	DETAILS	KMS	RATE/KM	TOTAL
			Sub Total			

GL Acct No.	4315
Cost Centre	

OTHER EXPENSES

DATE	COST CENTRE	GL Acct No.	DETAILS	COST (Excl GST)	GST	TOTAL
			Sub Total $			

IMPORTANT

This form is for internal use only. Please attach all supporting documentation (tax invoices/receipts etc.) Credit card receipts are NOT tax invoices.

CLAIMANT SIGNATURE _____ BANK AND BRANCH _____

AUTHORISED BY (NAME AND SIGNATURE) _____ ACCOUNT NAME _____

DATE _____ BSB _____

☐ Petty Cash ☐ Cheque ☐ Bank Deposit/EFT

PAYMENT METHOD _____ ACCOUNT NUMBER _____

PAID BY EFT RUN/CHQ NO. _____ DATE PAID _____