|  |  |  |
| --- | --- | --- |
|  |  | 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 HouseTopcliffe LaneWakefieldWF3 1WE |
| **Return To:** Department of Postgraduate Dental EducationVantage Office ParkOld Gloucester RoadHambrookBristol BS16 1GW |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Bank Account Number | Bank Account Sort Code | bank account name | Swift code (overseas only) | E-mail address forremittance 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 | £  |

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