

## Funding Reimbursement Travel & Accommodation Claim For Funded Trainees HWD Postgraduate Nursing (District)

**Office Use Only:**

Ref ID: HWPGN-\_\_\_\_\_-\_\_\_\_\_ PO number:\_\_\_\_\_ Date received by PDU:

- To support this claim proof of payment is required –please submit original GST tax invoices/receipts including name and dates.
- Bank account details on formal bank documentation – including name and number of account.
- All claims should be submitted as soon as possible at the end of the funded period and must be received by 31 March the year following funding.

**Claimant Details:**

Trainee name: .....

Employee ID number (if applicable) .....

Employee e-mail address .....

Employer name: .....

Submission date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Funding period (year of funding): \_\_\_\_\_ semester/s  
(circle): 1 2

Training provider/s: .....

Course number: ..... Course name: .....

<b>Travel and accommodation claim:</b> From place of employment to training provider where $\geq$ 100km one way.	<b>Dates</b> - list study block dates here:
	<b>Actual costs \$</b>
<b>Airfares:</b>	\$
<b>Accommodation:</b>	\$
<b>Taxis/shuttles/buses &amp; parking:</b>	\$
<b>Mileage: provide kms/trips - supply petrol receipts.</b>	\$
<b>Total claim:</b>	\$
<b>Approved claim (office):</b>	\$

**Claimant comments:**

.....  
.....  
.....

**Claims must be submitted to:**

PDU Administrator, c/- Practice Development Unit (Otago)  
PG Nursing Education Office, 1<sup>st</sup> floor Fraser Building, 464 Cumberland Street, Dunedin Box 20,  
Dunedin Hospital, Private Bag 1921, Dunedin, 9054.

**For claim queries, please contact:**

E-mail: [HWDFunding@southerndhb.govt.nz](mailto:HWDFunding@southerndhb.govt.nz)

Jo Dobson: Coordinator – Postgraduate Nursing Education  
DDI: (03) 470 9675 or extn 59675

Kylie Legg: Administrator – Postgraduate Nursing Educator  
DDI: (03) 470 9673 or extn 59673

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<b>PDU Manager:</b>	<b>Sign:</b>	.....	<b>Date:</b> ____ / ____ / ____
<b>PGNE Coordinator</b>	<b>Sign:</b>	.....	<b>Date:</b> ____ / ____ / ____
<b>PGNE Administrator:</b>	<b>Sign:</b>	.....	<b>Date:</b> ____ / ____ / ____

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Claim sent to Accounts Payable: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Coding default: **430 – 5215 – 2210 - 00071**