APPLICATION FOR MEDICAL REIMBURSEMENT

(Please fill ALL fields)

I would like to apply for medical reimbursement according to my eligibility as allowed by the University. The details are as follows: -

Name of Staff :..... Staff No.:.....

K/C/D/I/O :..... H/P No. :.....

Bank Account No : .....

Bank Name :.....

NO	NAME	RELATIONSHIP	DIAGNOSIS / TREATMENT	HOSPITAL / CLINIC	AMOUNT (RM)
1					
2					
3					
4					
5					
TOTAL CLAIM					

(Please use another form whenever necessary)

Thank you, Wassalam

.....

(Signature of applicant)

Date: .....

To avoid delay in payment, please ensure that the particulars are filled completely. Please attach original receipt for every claim. Please make your own copy before submit **(if necessary).**

Office use: ☐ Approved ☐ Not Approved

Verified by:

Remarks:

_____

_____

_____

_____

Chief Medical Officer

Date: