KUISCELL/HR/15/FORM 1

MONTHLY EXPENSES CLAIMS FORM

NAME : ______________________________ DEPARTMENT : ____________________

STAFF NO. : ______________________________ DESIGNATION : ____________________

MONTH : ______________________________

CATEGORY	DESCRIPTION	AMOUNT (RM)
AIRFARE (OWN PURCHACE)		
MILEAGE		
PETROL		
TOLL		
PARKING		
TRANSPORT (TAXI / CAR CENTAL)		
HOTEL / ACCOMMODATION		
MEALS ALLOWANCE		
TELEPHONE		
ENTERTAINMENT		
MEDICAL		
ATTENDANCE		
OTHERS (PLEASE SPECPY)		

TOTAL EXPENSES : ______________

LESS ADVANCES : ______________

BALANCE DUE : ______________

CLAIMED BY (SIGNATURE / NAME / DATE) : ____

VERIFIED BY (SIGNATURE / NAME / DATE) : ____

APPROVED BY (SIGNATURE / NAME / DATE) : ____

NOTES :

1. All claims must be submitted before 7th every month.
2. All claims will be paid within 30 working days.
3. All claims must be supported by original receipts bills invoices.
4. Please paste the small sizes receipts on A4 paper.

ATTACHMENT TO EXPENSES CLAIMS FORM

MILEAGE

DATE	PURPOSE	DISTANCE (KM)	RATE (RM)	AMOUNT (RM)

TOTAL MILEAGE : ________________

ENTERTAINMENT

DATE	CLIENT / BIZ ASSOCIATE		PURPOSE	STAFF INVOLVED	AMOUNT (RM)
	COMPANY	PERSONS			

ACCOMODATION

DATE	HOTEL/ LOCATION	PURPOSE	RATE (RM)	AMOUNT (RM)