

**APPLICATION FOR REIMBURSEMENT OF RELOCATION AND ASSOCIATED EXPENSES**

NAME: ...............................................................................................................

NEW POST: ................................................................. BAND ......................

DATE OF APPOINTMENT: .....................................................................

HOME ADDRESS: ...........................................................................................

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

PHONE NO: Home: .................................... Work: ....................................

Mobile: …………………………..

DETAILS OF FAMILY:

SPOUSE / PARTNER ...................................................................... YES/NO

NO. AND AGES OF CHILDREN ......................................................................

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

BEFORE ANY EXPENSES RELATING TO HOUSE PURCHASE WILL BE REIMBURSED YOU WILL BE REQUIRED TO - provide details regarding your old and new properties, for comparison purposes.

Application for reimbursement should be made as and when expenses are incurred using the attached form. WHERE APPLICABLE, ORIGINAL RECEIPTED BILLS MUST ACCOMPANY ALL SUCH APPLICATIONS.

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**RELOCATION AND ASSOCIATED EXPENSES**

PARTICULARS OF ACCOMMODATION IN OLD AREA

1. Type of house (i.e. villa/bungalow/flat, etc.)..........................................

2. Number of main rooms: No.

Living Room ..............

Dining Room ..............

Bedroom ..............

Kitchen ..............

Utility Room ..............

Bathroom ..............

Other (Specify) ..............

3. Central Heating: YES/NO\*

4. Detached/semi-detached/terraced: .................................................

5. Rent payable (tenancy): ..........................................................................

PARTICULARS OF ACCOMMODATION IN NEW AREA

1. Type of house (i.e. villa/bungalow/flat, etc.) .......................................

2. Number of main rooms: No.

Living Room ..............

Dining Room ..............

Bedroom ..............

Kitchen ..............

Utility Room ..............

Bathroom ..............

Other (Specify) ..............

3. Central Heating: YES/NO\*

4. Detached/semi-detached/terraced: .......................................................

5. Rent payable (tenancy): .......................................................................

**ESTATE AGENTS/SOLICITORS DETAILS OF BOTH PROPERTIES MUST BE ATTACHED TO THIS FORM**

Certificate: I certify that to the best of my knowledge the above particulars are correct and that no expenses in respect of relocation are to be claimed from any other source.

Date: .............................................. Signature: .......................................................

**Note**: Should it be confirmed at a later date that any of the information given was known to be false at the time of completion of this form the employee may be required to repay to NHS Fife the whole or such proportion of the expenses paid as NHS Fife may deem proper in the circumstances.

Checked by General Manager/Head of Service

Date: .............................................. Signature: .......................................................



**RELOCATION AND ASSOCIATED EXPENSES**

***Certificate of Undertaking – Permanent Posts***

In consideration of receiving payment of relocation and associated expenses, I

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

undertake that I will not leave NHS Fife within a period of two years, unless the further move is as a result of unforeseen circumstances which are serious enough to justify releasing me from this undertaking.

I confirm that no other assistance with relocation and associated expenses has been or will be received from any other source.

I also understand that if I break this undertaking I may be called upon to refund the whole, or part of, any expenses paid.

Signed: .................................................................. Date: ..........................................

To be completed by appointing manager

Date of commencement with NHS Fife: ...........................................

Date employee would be eligible to be released from above undertaking: .....................

Date sent to accounts payable – Fife.arinvoice@nhs.scot

RELOCATION EXPENSES POLICY

*Certificate of Undertaking for Fixed Term/Temporary Contracts for a duration of less than two years*

I …………………………………… undertake to move my present residence and I understand that my fixed term/temporary\*(delete as appropriate) contract with NHS Fife is due to expire on …………….and that at this time I will be liable at the date of termination of employment to repay all or part of any assistance received in accordance with NHS Fife’s Relocation Expenses policy.

I confirm that no other assistance with removal and associated expenses has been or will be received from any other source.

I understand that if I break this undertaking I will be required to refund all or part of the allowance paid in accordance with the policy.

Signed ……………………………… Date …………………………..

To be completed by appointing manager

Date of commencement with NHS Fife: ...........................................

Date sent to accounts payable – Fife.arinvoice@nhs.scot

# RE4 - APPLICATION FOR REIMBURSEMENT OF REMOVAL EXPENSES

|  |  |
| --- | --- |
| **Item Claimed** | **Amount £** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| **Total** |  |

Icertify that the above particulars are correct.

Signed: …………………………………………….. Date: …………………………

Post: ………………………………………………. Dept: …………………………

If you wish for the payments of the above to be paid directly into your bank account please detail your sort code, account number and account name below, otherwise payment will be made by cheque:-

Sort Code:

Account No:

Name of Bank/Building Society

Name of Account Holder

Authorised Signatory signature:

…………………................................................... Date: …………………………..

Financial code (to be completed prior to sending to Finance)

F……………………………..

Checked by General Manager/Head of Service

Signed: ..…………………………………………… Date: …………………………

Date sent to accounts payable – Fife.arinvoice@nhs.scot