

PAPHR First Responder Expense Claim Form

Financial Period Ending: _____

First Responder Group: _____

First Responder Claimant: _____

| Date | Claim Code | Description | Amount Claimed | Receipt Included | Total |
|------|------------|-------------|----------------|--|-------|
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ |

| | |
|-------------|----|
| Total Owing | \$ |
|-------------|----|

First Responder Claimant Signature: _____

First Responder Co-ordinator Signature: _____

Cheque Number Issued: _____

RECEIPTS MUST BE ATTACHED TO THIS FORM TO BE VALID

