KPJ KLANG
SPECIALIST HOSPITAL

MILEAGE/ TRAVELING CLAIM FORM FOR THE MONTH OF _____ 20 _____

NAME : _____
POSITION : _____
DEPT : _____
VEHICLE NO : _____
STAFF NO : _____

DATE	TIME		DETAILS OF TRAVEL		DETAILS OF DUTIES	TOLL & PARKING (RM)	ALLOW. (RM)	KM (kilometer)	AMOUNT (RM)
	FROM	TO	FROM	TO					
					TOTAL				
					KM x RM 0.70				
					TOTAL TOLL TICKET & PARKING				
					TOTAL CLAIM				

DECLARATION	CERTIFICATION OF DEPARTMENT HEAD	CERTIFICATION OF THE HCM	VERIFICATION	AUTHORISATION
I declare that the above disbursements have been actually paid by me and that the claim allowance claimed are proper and payable as under the rules and regulations of KPJ KLANG SPECIALIST HOSPITAL	I certify that the above claims are correct and payable unless otherwise amended or cancelled by me	I certify that the above claims are correct and payable unless otherwise amended or cancelled.	I verify that above claim are correct and payable unless otherwise amended or cancelled.	Please pay the above claims as otherwise amended or cancelled by me
Signature:.....	Signature:.....	Signature:.....	Signature:.....	Signature:.....
Date:.....	Date:.....	Date:.....	Date:.....	Date:.....