VOUCHER OF EXTRA HOLIDAY / OFF DAY PAYMENT
NURSING OFFICERS/ FAMILY HEALTH OFFICERS:

Emp No	
Month	
Vr. No	

A CLAIMANT DECLARATION

Name of Nursing Office				Grade	
Institution of Work				Basic Salary	
Hp. Rate/ Day				Hourly Rate	
Week Beginning				Week Ending	
Total HP/OFF day worked		Total Extra Hours Work		Total Amount Claimed	

Particulars of Leave taken during the period of the claim :

DATES			No of Days	DATES			No of Days
No	From	To		No	From	To	
1							
2							
3							
4							
5							

HP/ OFF DAY DETAIL

Date	PH/ OFF Day	From	To	Hours	Unit Ward	Remarks	Sign of Claimant	Sign of Matron
Total no of days						Rate/Day	Total Payment	