UNIVERSITY FOR DEVELOPMENT STUDIES

MEDICAL CLAIM FORM

Name of Staff: …… Staff No.: …….

Faculty: …… Department: …….....

Name of Patient: ……...

Relationship with Patient: ……

Amount to be Refunded: ……..

Amount in Words: ……

Signature: ……... Date: ……

Recommended by: ……. Date: …….

HOD/Dean

Approved by: …… Date: ……..

Registrar

……

Official Use only

Last Refund: ……..

Director of Finance: ……. Date: …….