**Non-Staff Expense Claim Form**

**TO BE COMPLETED IN TYPEFACE (CAPITALS) ONLY**

**CLAIMANT DETAILS**

**Name of Claimant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Claimant signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reason for Claim: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IT IS CRITICAL THAT THIS FORM IS FILLED OUT IN ITS ENTIRETY ALONG WITH THE ACCOMPANYING DECLARATION**

 **Please also review the following links prior to completion**

[Guest Lecturer/Speaker - University of Galway](https://www.nuigalway.ie/payroll/payrollinformation/guestlecturerspeaker/), [External Examiners; Quality Reviewers; Subject Specialists - University of Galway](https://www.universityofgalway.ie/payroll/externalexaminersprogrammereviewerssubjectspecialists/)  [QA304 – Travel and Subsistence](https://www.universityofgalway.ie/payroll/travel---subsistence-expenses/)

***Claimant’s Bank Details:***

***For Euro payments in Ireland/ within the EU and Sterling payments to the UK***

Bank Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bank Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bank Account Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bank Sort Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IBAN Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bank Swift/BIC \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***For all other worldwide payments***

Bank Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bank Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bank Account Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bank Routing Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bank Swift/BIC \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***Details of claim****:* (Original receipts must be submitted in respect of all costs claimed.)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date** | **Description: Meeting/Conference/Other** | **Cost Centre** | **GL Code** | **Total Cost** | **Currency** |
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|  |  |  | **TOTAL****Euro/GBP /USD** |  | **One Currency ONLY per claim** |

***Claims for reimbursement of travel expenses must be made as soon as possible and, in any event, no later than 3 months after the date incurred****.* **All travel and subsistence claims equal to or** **exceeding €2,000** **must be authorised by relevant** **UMT member** **(or nominee)
*This form and declaration, when fully complete and authorised by Budget Holder must be submitted to:***

***NonStaffExpenseClaims@universityofgalway.ie***

** Budget Holder Declaration**

 **I authorise the proposed payments to be made and confirm the following:**

*1. I have performed a callback procedure or met face to face, to confirm the existence of the individual and the associated bank details
2. I have received a recent bank statement header from the beneficiary. The gathering of payment details for each individual (IBAN numbers etc.) has been inputted completely and accurately
3. I have a tracking system to record evidence of an existing commitment, approval requests & approvals, bank details of the recipient and dates of bank transfers
4. I have reviewed all proposed payments to ensure no duplicates
5. I will retain all records for audit purposes*

**Claimant/Beneficiary Name: Amount EUR:** **Cost Centre:**

**To be signed by Budget Holder:**

**Date:** **Name:**  **Signature:**

**To be signed by UMT member (if the claim is equal to or greater than €2,000):**

**Date:** **Name:**  **Signature:**