

# REIMBURSEMENT OF INCIDENTAL EXPENSES

Internet: <https://employee.gov.bc.ca>

**Freedom of Information and Protection of Privacy Act**

This form is required to process your request for reimbursement and the collection of personal information complies with the *Freedom of Information and Protection of Privacy Act*. If you have any questions about the collection of this information, please contact your Pay Office.

**Please type or print clearly**

**INSTRUCTIONS:**

This form is to be completed by an employee claiming reimbursement for expenditures (that have been paid for personally and are eligible for reimbursement), as stated in the Master or Component Agreements for BCGEU, PEA, Nurses or Terms and Conditions for Excluded Employees.

**EMPLOYEE** – Complete PART 1, the APPLICABLE REIMBURSEMENT SECTION and PART 5. Attach **ORIGINAL** receipt and forward to Expense Authority for approval signature.

**EXPENSE AUTHORITY** – Complete PART 6, approve, retain copy of reimbursement form and **ORIGINAL** receipt. Forward approved reimbursement form to Pay Office for processing.

**Note:** Reimbursement for Medical/Dental Travel Expenses (Part 3) and Boot Allowance (Part 4) can be processed directly through Time on Line (TOL). Please **DO NOT** submit this form to the Pay Office if you are claiming the reimbursement through Time On Line.

**PART 1 – EMPLOYEE**

EMPLOYEE LAST NAME	FIRST NAME	MIDDLE INITIAL	EMPLOYEE ID	DEPT ID	POSITION NO.	CALENDAR YEAR OF REIMBURSEMENT
MINISTRY/EMPLOYER NAME			EMPLOYEE CLASS		APPOINTMENT STATUS	
			<input type="checkbox"/> BCGEU <input type="checkbox"/> SCHEDULE A <input type="checkbox"/> OIC <input type="checkbox"/> MGMT. EXCL. <input type="checkbox"/> NURSES <input type="checkbox"/> OTHER: <input type="checkbox"/> PEA <input type="checkbox"/> SAL. PHYSICIANS		<input type="checkbox"/> REG <input type="checkbox"/> FULL-TIME <input type="checkbox"/> AUX (WITH BENEFITS) <input type="checkbox"/> PART-TIME <input type="checkbox"/> AUX (WITHOUT BENEFITS)	

**PART 2 – ASSOCIATION REIMBURSEMENT (ARE)**

BCGEU Regular Full-time Employee  
 NURSES/PEA/MGMT EXCL Regular Employee

\$ \_\_\_\_\_ [Approved Fee Schedule](#)

Note: Employees cannot claim professional dues reimbursed by the Employer on their individual income tax return.

Refer to applicable Collective Agreement/Terms and Conditions for more information.

**PART 3 – MEDICAL/DENTAL TRAVEL EXPENSES (MTR)**

Regular and Benefited Auxiliary Employee  
 MAXIMUM \$500 per calendar year

\$ \_\_\_\_\_

**DO NOT SUBMIT THIS FORM TO THE PAY OFFICE IF CLAIMING REIMBURSEMENT THROUGH TOL**

Refer to applicable Collective Agreement/Terms and Conditions for more information.

**PART 4 – BOOT ALLOWANCE (CLN)**

BCGEU/PEA/MGMT EXCL/SCH A/OIC Regular and Specified Benefited Auxiliary Employee (Once per calendar year – refer to Component Agreement)

\$ \_\_\_\_\_ Component Agreement: \_\_\_\_\_

**DO NOT SUBMIT THIS FORM TO THE PAY OFFICE IF CLAIMING REIMBURSEMENT THROUGH TOL**

**PART 5 – CERTIFICATION**

I certify this claim is a true statement of reimbursement or allowance to which I am entitled as detailed above and that I have incurred the expense.

EMPLOYEE SIGNATURE	PRINT NAME	DATE SIGNED
X		YYYY MM DD

**PART 6 – EXPENSE AUTHORITY APPROVAL**

CERTIFIED CORRECT PURSUANT TO SECTION 32 & 33 OF THE FINANCIAL ADMINISTRATION ACT AND RELATED POLICIES.

EXPENSE AUTHORITY SIGNATURE	PRINT NAME	DATE SIGNED
X		YYYY MM DD

**PART 7 – PAY OFFICE USE ONLY**

PAY PERIOD END DATE	EARNINGS CODE	ALLOWANCE AMOUNT	CERTIFIED CORRECT/ENTERED INTO CHIPS BY	DATE ENTERED INTO CHIPS
YYYY MM DD		\$	X	YYYY MM DD