RNUNL DEPENDANT CLAIM FORM

Name: _____

Mailing Address: _____

Phone: home_____work_____

E-mail: home _____work_____

RNUNL Event/Activity: _____

I request payment as detailed below.

_____ _____

Signature ***Date***

Please complete the non-shaded areas only ~ shaded areas for Provincial Office calculation.							**Totals**
Date							
Shift Scheduled (ie. D8, D12, E, N12)							
Caregiver Start Time							
Caregiver End Time							
Total Hours per Day							Box 1
Amount Paid to Caregiver per Day							Box 2 $

Note:

a) Members will not be reimbursed for dependant care expenses she/he would have normally incurred.

b) The rate of payment shall be the hourly minimum wage to a maximum of 8 hours per day.

c) Receipts must be provided and must be prepared and signed by the caregiver indicating the date and the number of hours for which the caregiver was paid.

d) Dependant care expenses that exceed the amounts specified in this policy may be submitted to the Provincial President for special consideration.

Caregiver Verification (or attach separate receipt):

I verify that I have provided care as indicated above.

Signature of Caregiver: _____ **Date:**_____

Verified & Approved by: _____ ***Date:*** _____

On behalf of RNUNL Provincial Office

Total Amount Approved

$

Registered Nurses' Union Newfoundland & Labrador, P.O. Box 416, St. John's, NL A1C 5J9
Tel (709) 753-9961 / 1-800-563-5100, Fax (709) 753-1210, www.rnunl.ca