



UNIVERSITY OF NAIROBI HEALTH SERVICES

DRUGS REFUND CLAIM FORM

CLAIMANT NAME.....**PAYROLL NO**.....

COLLEGE.....**GRADE**.....

DEPARTMENT.....

MOBILE No..... **(Necessary for M-Pesa Payment)**

TERMS OF SERVICE (Tick appropriate) Permanent contract Temporary

I wish to apply for a refund of the enclosed receipt(s) amount to Khs..... In respect of

Self Dependant (Tick appropriate)

<u>FULL NAME</u>	<u>SEX</u>	<u>AGE</u>	<u>RELATIONSHIP</u>
.....
.....

The reason why service was not offered at the University Health Services was.....

I am eligible for medical refund under the current University regulations and my terms of service.

I certify the information given above to be true.

Applicant's Signature..... Date.....

RECOMMENDATION BY PHARMACIST

I confirm that the applicant is eligible / not eligible for the refund under the University of Nairobi regulation and his/her terms of Service

Application is Approved / Not Approved

Remarks.....

Amount approved for refund Khs.....

Signed By..... Designation..... Date.....

BURSAR'S OFFICE – UHS

