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| **EXCESS TRAVEL EVALUATION FORM** |

*NB. Assignment Change Form needs to have been submitted for change of base before form will be considered by HR*

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| **Employee Details** |
| First Name: |  | Surname: |  |
| Employee No: |  |
| Home address including postcode *(at date of transfer)*: |  |
| Car User Type*Please delete as appropriate* | Private Vehicle / Lease Car / Salary Sacrifice  |

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| **Assignment Details** |
| Job Title: |  |
| Previous base location (full address required, including postcode): |  |
| New base location (full address required, including postcode): |  |
| Days worked per week |  | On average, how many days per week will you be attending your new base? |  |
| Date of transfer: |  |
| Type of transfer: | Permanent / Temporary*(please delete as appropriate)* | If temporary transfer, what is the end date? |  |

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| **Eligible Claim Calculations:** |
| 1. Journeys by private vehicle (including Lease & Salary Sacrifice) | HR Validation *(for HR Use)* |
| Home to old base (one-way mileage) |  | A |  |
| Home to new base (one-way mileage) |  | B |  |
| Difference (A-B) |  | C |  |
| **If you will be making your journey via public transport please also complete Section 2 below;** |  |
| 2. Journeys made by public transport (complete section 1 first) |  |
| Transport Method |  |  |
| Home to old base (one-way fare) |  | D |  |
| Home to new base (one-way fare) |  | E |  |
| Difference (D-E)  |  | F |  |

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| **Employee Declaration** |
| I declare that the information I have given on this form is correct and complete and that I have not claimed elsewhere for the payment detailed on this claim form. I understand that if I knowingly provide false information this may result in disciplinary action and I may be liable for prosecution and civil recovery proceedings. I consent to the disclosure of information from this form to and by East Coast Community Healthcare and the Counter Fraud Service for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud. |
| Signed: |  |
| Dated: |  |

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| **Line Manager Declaration** |
| I am an authorised signatory for my department. I am signing below to confirm that the claim that I am authorising is accurate and I approve payment. I understand that if I knowingly authorise false information this may result in disciplinary action and I may be liable for prosecution and civil proceeding. I consent to the disclosure of information from this form to and by East Coast Community Healthcare and the Counter Fraud Service for the purpose of verification of this claim and the investigation, detection and prosecution of fraud. |
| Signed: |  |
| Print Name: |  | Dated: |  |

**Please send the fully completed form to HR either by scanned copy to** **ecch.hradmin@nhs.net** **or by post to**

**Hamilton House, Battery Green Road, Lowestoft, Suffolk, NR32 1DE**

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| **HR USE** |
| Claim validated: | Yes;[ ] Home to New Base is further from Home to Old Base[ ] Notification of Change received | No; (please state why) |
| One-way mileage allowance: |  |
| Claim period dates  | Start date: |  | End date: |  |
| Employee Vehicle User Type | Standard | Regular | Salary Sacrifice | Lease Car |
| Actions (please tick when processed): | [ ] Form scanned[ ] Details added to excess travel log[ ] Employee and Line Manager emailed to confirm eligibility[ ] Form filed on personnel file[ ] For Lease and Salary Sacrifice Car user – Knowles contacted with information |
| Signed: |  |
| Date:  |  |