Speech and Hearing BC

402, 1755 West Broadway, Vancouver, BC V6J 4S5
Phone: 604-420-2222 Toll Free: 1-877-BCASLPA
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Policy V.14.B - Prior Approval for Reimbursement of Lost Wages Form

CLAIMANT'S NAME: _____

ADDRESS: _____

_____

_____

TELEPHONE: _____

FAX: _____

I, THE CLAIMANT, ACKNOWLEDGE THAT I HAVE MADE EVERY EFFORT TO REARRANGE MY WORK COMMITMENTS AND OBLIGATIONS TO ACCOMMODATE THE BCASLPA BUSINESS TO BE PERFORMED AS DESCRIBED BELOW TO RESULT IN MY LOSING THE LEAST AMOUNT OF WAGES. THIS INCLUDES HAVING MY EMPLOYER APPROVE THE BCASLPA RELATED BUSINESS TO BE COMPLETED ON MY EMPLOYER'S TIME.

APPOINTED BY WHOM: _____

AT WHAT DATE: _____

FOR WHAT PURPOSE: _____

_____

_____

DAY(S) FOR WHICH REQUESTING REIMBURSEMENT: _____

_____

CLAIMANT'S SIGNATURE: _____ APPROVED BY: _____
(TREASURER)

DATE OF SUBMISSION: _____ DATE OF APPROVAL:_____

Reviewed: April 27, 2021