



Speech and Hearing BC

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**Policy V.14.B - Prior Approval for Reimbursement of Lost Wages Form**

Claimant's Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

I, the claimant, acknowledge that I have made every effort to rearrange my work commitments and obligations to accommodate the SHBC business to be performed as described below to result in my losing the least amount of wages or income. This includes having my employer approve the SHBC related business to be completed on my employer's time.

Appointed by whom: \_\_\_\_\_

At what date: \_\_\_\_\_

For what purpose: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Amount Claimed: \_\_\_\_\_

day(s) for which requesting reimbursement:

\_\_\_\_\_

\_\_\_\_\_

Claimant's signature: \_\_\_\_\_ Approved by: \_\_\_\_\_

(Treasurer)

Date of submission: \_\_\_\_\_ Date of approval: \_\_\_\_\_