



Wide Bay Regional Swimming Association

Officials Expense Claim Form

Date: _____

Name: _____

EXPENSE	AMOUNT
TOTAL AMOUNT CLAIMED	

*Per Day Allowance: \$150

*Overnight Allowance: \$100 (per household)

Account Name: _____

BSB: _____

Account Number: _____

Claimant Signature: _____

AUTHORISED BY COMMITTEE

MEMBER 1: _____ POSTION: _____

SIGNATURE: _____

MEMBER 2: _____ POSTION: _____

SIGNATURE: _____

PAID: / /

REF NUMBER: