**Relocation Expenses Application Form**

**Details of New Appointment**

|  |  |
| --- | --- |
| Name |  |
| Post |  |
| Job Reference No. |  |
| Start Date |  |
| Permanent/Temporary Appointment |  |

**Tick the relevant box to determine the level of assistance for the application:**

|  |  |
| --- | --- |
| Neither sale nor purchase of a property  | **Band A ** |
| Sale of a property only | **Band B ** |
| No sale - purchase of a property within the local area only | **Band B ** |
| Sale of a property and purchase of a property within the local area | **Band C ** |

**Address Details – if applicable**

|  |  |
| --- | --- |
| Current Address | Proposed / New Address  |
|  |  |

**Please list below the amounts you wish to claim and the elements of the criteria you wish to claim for:**

**Initial Claim  Ongoing Claim **

**Declaration:**

I wish to apply to NHS Scarborough and Ryedale CCG for assistance with the relocation expenses actually and necessarily incurred by me in relocating to take up my new appointment. In doing so I declare that the information and expense details provided by me on and/or with this form are correct and that no other member of my household has received, or intends to claim for these expenses from another employer. I understand that if I provide false information I may be liable for disciplinary, prosecution and civil recovery proceedings. I consent to the information on this form being used for the purposes of the prevention, detection and investigation of fraud.

I understand that as a condition for making payment the CCG requires an undertaking that if I leave the CCG within a period of 24 months I will voluntarily repay relocation expenses paid by the CCG. The repayment would be based on 1/24 of the total amount paid by the CCG for each incomplete month within the first 24 months of employment and will be deducted from my final salary payment.

Signature of employee: ……………………………………………………………..

Date: ……………………………………………………………………………………..

Signature of recruiting manager:………………………………………………………..

Date:……………………………………………………………………………………….

**Workforce Information**

Relocation Assistance approved by CCG

Name:………………….…..……. Date………………

(Budget Holder/Senior Manager)

Payment request form sent to Accounts Payable Date …………………………..

Copy on personnel file – Date………………………………………………………….

HR Business Partner advised – Name: ………………. Date.……………..