



Hospital Allowance Application Form

When you are on transfer from your base hospital, or when admitted to a hospital more than 100 km from your current residence, you are entitled to an allowance of \$20/night of your stay. This is a contribution toward the extra costs incurred or lost income.

When filing this form please attach your discharge papers or have it signed by the CF Specialist Nurse or Charge Nurse of the ward.

PWCF Details

Name: _____ Birth Date: _____
 Address: _____

 City: _____ Email: _____
 Phone: _____
 Postcode: _____ CF Branch: _____

Applicant:

Relationship: _____
 Address: _____

 (If different from above) _____ Email: _____
 Phone: _____

Details of Application:

Application Date: _____
 Hospital Check-In Date: _____ Discharge Date: _____
 Hospital: _____
 Signature of Applicant: _____

Have you attached a copy of the Discharge papers? If not available, please have your hospital stay verified by the CF Specialist Nurse or the Nurse in Charge of the Ward.

Verification:

Name: _____ Position Held: _____
 Signature: _____

Details of Payment:

Payment Method: Direct Deposit Account No: _____
 Cheque Payable To: _____

Your claim will be dealt with as quickly as we are able, and the grant can be deposited directly into your bank account. **Please note: we accept no responsibility for payments going astray if you provide incorrect bank details.**

Alternatively, a cheque can be mailed to the Applicant's address if you prefer.

Please mail this form (with discharge papers or verification) to;
Administration Manager, CF Association, PO Box 8241, Christchurch