ACCRA TECHNICAL UNIVERSITY

ATUCF16 - CLAIM FORM FOR OVERTIME/CALL-IN ALLOWANCE **YEAR:** _____

Part A - Details of Claimant

Name: _____ Staff Number: _____ Designation: _____

Faculty/Department/Section/Unit: _____ Telephone Number: _____

Part B - Details of Claim

Overtime Month (Please tick): [ ] Jan [ ] Feb [ ] Mar [ ] Apr [ ] May [ ] Jun [ ] Jul [ ] Aug [ ] Sep [ ] Oct [ ] Nov [ ] Dec

Please state below relevant details of the overtime claim							
Date	**Normal Approved Working Hours**	**Time Reported for Normal Duty**	**Time Closed for Normal Duty**	**Time Reported for Overtime**	**Time Closed for Overtime**	**Number of Overtime Hours**	**Nature of Work Done**

** Please add extra sheet or form if the need be.*

This Form has been designed in accordance with Section 16.8 of the University Accounting Policies and Procedures Manual. It is to be used only for the claim for which it is meant.

Claimant's Declaration *(Please read carefully before signing)*

I declare that the information provided above are accurate and free from material misstatement.

I certify that the overtime stated above were done by me and no other person.

Signature of Claimant **Date(DD/MM/YYYY)**

Part C - Authorising Officer (s)

Head of Department **Signature** **Date(DD/MM/YYYY)**

Part D - Certification by the Internal Auditor

We are satisfied that the requested claim is genuine and supported by relevant documentation.

Signature of Internal Auditor **Date(DD/MM/YYYY)**

Part E - Approving Officer *(Kindly indicate and sign)*

Approved [ ] Not Approved [ ]

Vice-Chancellor **Signature** **Date(DD/MM/YYYY)**

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