EXTRA DUTY ALLOWANCE CLAIM FORM

SALARY SCALE.....CHECK NO.....

HEALTH FACILITY.....

NAME.....DESIGNATION.....SECTION.....

DATE	DAY	TIME		DETAILS OF WORK DONE	CLAIMANT'S SIGNATURE	SUPERVISOR'S SIGNATURE
		FROM	TO			

Calculation

Week Days.....Rate.....Tshs.....

Weekend/Public Holidays..... Rate.....Tshs.....

TOTAL Tshs.....

Extra Duty has been checked by: NAME.....

Signature.....

Medical Officer I/C