

LOSS OF EARNINGS CONFIRMATION FOR ANTHONY NOLAN DONOR / COMPANION



PLEASE SUBMIT THE SIGNED FORM BY EMAIL TO YOUR DONOR PROVISION COORDINATOR

If you must take unpaid leave from work, if you are self-employed or if your employer requires reimbursement for your time off we will reimburse loss of earnings (up to a maximum of £250/day) for your medical assessment and/or donation day(s). You and/or your companion and employer, if appropriate, must complete If you have any questions please email donorprovision@anthonymolan.org, or dial 0207 424 6699 to speak to a member of the team

Donor/companion contact details

Salary details

Name of donor/companion		Job title		Contracted working days (e.g. Monday - Friday)	
Address		Annual salary (£s)			
		OR			
Mobile number		Hourly rate £/hour		Contracted weekly hours (e.g. 40 hours)	

Dates of absence

	Date from		Date to (if relevant)		Total days taken
Medical					
Donation			Date to		
	Date from		Date to		

Total amount claimed based on the above (if left blank we will calculate based on the information provided)

(£s)		Any additional comments	
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PART A: FOR EMPLOYED PERSONS ONLY

Please tick relevant

Amount claimed to be reimbursed fully to the employee as they were not paid during the dates above

(please fill in bank details at end of form)

Amount claimed to be reimbursed fully to the employer as the employee was paid by us whilst absent during the dates above

(please fill in bank details at end of form)

Employer contact details

Company/Organisation name		Authorised by (full name)	
Switchboard number		Department	
Registered address		Email address	
		Direct number	

PART B: FOR SELF-EMPLOYED PERSONS ONLY

Please provide **one** of the following documents

Documents Required

Please state documents submitted

Latest self-assessment return	
Income statement from your accountant for the last year (or from start of self-employment if less than one year)	
Copy of last 6 months bank statements / last six months sales invoices	

PART C: FOR ALL: BANK ACCOUNT DETAILS FOR REIMBURSEMENT

Bank name		Account number	
Account holder name		Sort code	

Signature of claimant

(authoriser under employer contact details, if relevant)

Date

Date

PART D: FOR ANTHONY NOLAN TO COMPLETE

Donor ID		Patient ID	
Project Code		Calculations	