

GERRARDS CROSS PARISH COUNCIL

TAXI CONCESSIONARY FARES SCHEME REIMBURSEMENT FORM

Member's Details

Registration Number _____

Name _____

Address _____

Telephone Number _____

I wish to claim / I authorise _____ to collect refund on my behalf *(delete as required)*

Dates Travelled :

Fare for each one-way journey		Refund per journey	Amount Claimed
£6	Calcot Medical Centre and Misbourne Surgery	£3	
£6	Dentist/ Optician etc. in GX or Chalfont. St Peter	£3	
£10	Wexham Park Hospital	£7	
£14	Amersham General Hospital.	£10	
£14	Amersham Dental Centre.	£10	
£17	High Wycombe General Hospital.	£12.25	
£25	Heatherwood Hospital.	£18.25	
£20	Mount Vernon Hospital	£14.50	
£22	Princess Margaret Hospital	£16.00	
£22	King Edward VII Hospital	£16.00	
Total: £		Total: £	Total: £

Appropriate receipts for all journeys must be attached.

Refunds must be claimed within four weeks of the date of the journey.

Signature of member/authorised collector _____

You or your authorised collector will be required to produce your members pass when collecting the refund.