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