Office Supplies Expense Claim Form

Claimant Name:
_____
Department:
_____
Date:
_____ / _____ / _____
Employee ID:
_____
Period Covered:
_____ / _____ / _____ to _____ / _____ / _____

Expense Details

#	Date of Purchase	Description of Item	Quantity	Unit Price	Total Amount	Vendor	Receipt Attached	Remarks
1	_____ / _____ / _____						[ ] Yes [ ] No	
2	_____ / _____ / _____						[ ] Yes [ ] No	
3	_____ / _____ / _____						[ ] Yes [ ] No	
Total Amount Claimed								

Claimant's Signature:

_____

Supervisor's Approval:

_____

Important Notes

- All claims must be supported with original receipts attached.
- Please ensure all details are filled out accurately before submission.
- Claims without proper approval and supporting documents may be rejected.
- Submit this form within the stipulated submission period for reimbursement processing.