



Gerrards Cross Town Council

TAXI CONCESSIONARY FARES SCHEME – Reimbursement Form (revised June 2017)

Name & Member No. _____

Address _____

I authorise _____ to collect this refund on my behalf

(Please print name)

For each <u>one- way</u> journey:			
Fare	Medical Facility/Surgery/Hospital	Refund per journey	Amount Claimed
£ 5	Medical facility/surgery in Gerrards Cross	£ 2	
£ 6	Doctors surgery/medical facility in Chalfont St Peter	£ 3	
£ 15	Wexham Park Hospital Spire Hospital, Wexham Upton Hospital, Slough Harefield Hospital	£ 8	
£ 17	Mount Vernon Hospital, Northwood	£ 9	
£ 18	Amersham General Hospital Amersham Dental Centre	£ 9	
£ 25	High Wycombe Hospital The Practice, Cressex Princess Margaret Hospital, Windsor King Edward VII Hospital, Windsor St Mark's Hospital, Maidenhead Bishopswood Hospital, Northwood	£ 13	
£ 28	The Chiltern Hospital, Great Missenden	£ 14	
£ 32	Heatherwood Hospital, Ascot	£ 16	
£ 45	Stoke Mandeville Hospital	£ 23	
£ 65	Frimley Park Hospital	£ 33	
	TOTAL		£

Appropriate receipts for all journeys must be attached

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

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

Signature of member/authorised collector _____