HEALTH SCIENCES ASSOCIATION
The union delivering modern health care

Wage Reimbursement Claim Form

(complete only if your employer is ***not*** billing HSA directly)

Member ID# _____ SIN# _____

Name _____ Work phone _____ Ext. _____
(Surname) (First Name)

Home address _____
(Street Address) (City) (Postal Code)

Facility _____ Discipline _____

Event date(s) from _____ to _____ Status ☐ Casual

Event _____ ☐ Part-time

Held at _____ ☐ Full-time

Wage reimbursement (SIN# required for T4 purposes)

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Date(s)							
Straight Time Hours							
Hourly Rate							
Subtotal Wages							

Do not write in shaded area (for office use only)

Benefit Amount							
GROSS WAGES							

R E T U R N T O :
Health Sciences Association of BC
180 East Columbia Street
New Westminster, BC V3L 0G7
fax: 604.515.8889
toll free fax: 1.800.663.6119

Gross Wages **$** _____
Less: Income Tax (_____)
CPP (_____)
EI (_____)
Union Dues (_____)
Net Wages (_____)
TOTAL AMOUNT (_____)

I hereby certify that the above information is correct.

Signature: _____ Date: _____

HSA is committed to using the personal information we collect in accordance with applicable privacy legislation. By completing this form, you are consenting to have HSA use the submitted information for the purposes of conducting our representational duties as a union, and in providing service to our members. For further information, please contact the HSA Privacy Officer. The full HSA policy is available online at www.hsabc.org.