



# OUT OF HOURS - Payment Request Form

*This document should be completed at the end of each Out of Hours session. OOHs supervisors must retain this document and submit it to [gpspecialtytraining.nimda@hscni.net](mailto:gpspecialtytraining.nimda@hscni.net) for payment.*

*Payments will only be processed on receipt of this document.*

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**OOHs Clinical Supervisor Name:** \_\_\_\_\_

<b>Name of Trainee</b> <i>(In block capitals)</i>	<b>Date of Session</b>	<b>OOHs Centre</b>	<b>Total Hours</b>	<b>Trainee Signature</b>

**Signature of OOHs Clinical Supervisor:** \_\_\_\_\_