MANDATORY/SPECIALIST TRAINING CLAIM FORM (B) 2024/25

*Please use a separate Claim Form for **each course***

*Please email the completed form to compliance@hcpa.co.uk. **Postal claims cannot be accepted.***

NAME OF HOME/SITE:	
FULL POSTAL ADDRESS (INC. POST CODE):	
CONTACT NAME:	
CONTACT TELEPHONE NUMBER:	
CONTACT EMAIL ADDRESS:	

NAME OF COURSE - *Choose the **one** subject that applies*

- ○ Assisting in Moving People
- ○ Moving & Handling Objects
- ○ Basic Life Support & First Aid
- ○ Equality, Diversity and Inclusion
- ◉ Fire Safety
- ○ Food Hygiene
- ○ Health and Safety Awareness
- ○ Medication Management
- ○ Mental Capacity and Liberty Safeguards
- ○ Person-Centred Care
- ○ Positive Behaviour Support
- ○ Recording and Reporting
- ○ Safeguarding and Protection of Adults at Risk
- ○ Long Term Conditions including Dementia, Neurological conditions, Autism, Mental Health & Learning Disabilities
- ○ End of Life Care

NAME OF TRAINING PROVIDER: ***(Organisation)***		*For HCPA use only*
NAME OF TRAINER: ***(Print name)***		*Received:*
DATE TRAINING CARRIED OUT:		
No. OF PLACES CLAIMED THIS TIME:		*Amount Due:*
DURATION OF COURSE (claims will not be paid for any course delivered in under 2.5 hours)		

You must enclose the following documents.

1. **and**	**Copy of course attendance record sheet signed by all Candidates and the trainer** *(1 copy needed):* **Please ensure that the register only has the names of your own staff attending - If you are running an 'open' course, please provide a separate register for each company as they may need this to claim for their own candidates. If candidates arrived to the course late or did not complete the full course, the claim for their place will not be approved. If the training was for a webinar of 2.5 hours or more please forward the post webinar email from the webinar provider to confirm attendance**	Tick to confirm this has been sent with this claim form ☐
2.	**Copies of candidates' HCPA approved course evaluation forms** *(1 for each Candidate):*	Tick to confirm this has been sent with this claim form ☐

The following declaration must be completed by the Employer submitting this claim:

I CERTIFY THAT THE CANDIDATES NAMED ON THE ATTENDANCE RECORD SHEET COMPLETED THE ABOVE TRAINING ON THE DATE SHOWN AND THAT ALL DETAILS ARE ACCURATE. I UNDERSTAND THAT WHILE HCPA MAKE EVERY EFFORT TO PAY AS MANY CLAIMS AS POSSIBLE, AT NO TIME WILL HCPA GUARANTEE THAT FUNDS WILL BE PAID.
AS A CARE PROVIDER, WE ARE ABLE TO FUND THIS COURSE FROM OUR OWN BUDGET IF NECESSARY.

Name:		**Position/Title:**		**Date**	

By filling in and returning this form you are agreeing to abide by the terms and conditions of the scheme. These are available on the HCPA website.