DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service Commissioned Corps

VOUCHER FOR REIMBURSEMENT FOR TRAVEL DEPENDENTS OF PHS COMMISSIONED OFFICERS

D.O. VOUCHER NUMBER	BUREAU VOUCHER NUMBER	
AGENCY DIVISION/ BUREAU/CENTER /AREA OFFICE		**PAID BY**
PAYEE *(Full Name)*	SOCIAL SECURITY NUMBER	
MAILING STREET ADDRESS	CITY	ZIP
OFFICIAL DUTY STATION	PHONE NUMBER	DATE OF P.O. *(mm/dd/yyyy)*

CERTIFICATION OF CLAIMANT

Payment is requested for travel by persons listed below who were my dependents on the effective date of applicable orders or other authority. Travel was performed with the intent of establishing a bona-fide residence. *(If any of the dependents claimed are other than a lawful spouse or unmarried legitimate child(ren) under 21 years of age, complete the appropriate certificate on the reverse*

FULL NAME	RELATIONSHIP TO OFFICER	BIRTH DATE OF CHILDREN

LOCATION OF DEPENDENTS *(On date of receipt of order/authority - Street, City, State, Zip Code)*	DATE OF DEPARTURE *(mm/dd/yyyy)*
DESIGNATED DESTINATION OF DEPENDENT(S) *(Street, City, State, Zip Code)*	DATE OF ARRIVAL *(mm/dd/yyyy)*

NOTE: *(When travel is from other than the vicinity of the old station or other than the vicinity of the new station, explain circumstances on the reverse.)*

GOVERNMENT TRANSPORTATION FURNISHED

MODE OF TRAVEL *(Rail, air, etc. If none, so state)*		T.R. NUMBER *(If used, attached copy)*	
PLACE OF DEPARTURE	DATE *(mm/dd/yyyy)*	DESTINATION	DATE OF ARRIVAL *(mm/dd/yyyy)*

I certify that this voucher and attachments are correct and payment has not been received. No prior claim has been presented by me or any member of my family for the travel of dependents as claimed herein.

SIGNATURE OF PAYEE		DATE *(mm/dd/yyyy)*
AUTHORIZED ALLOWANCE	DATE *(From) (mm/dd/yyyy)*	DATE *(To) (mm/dd/yyyy)*
DISLOCATION ALLOWANCE ☐ Yes ☐ No	AMOUNT	MILEAGE

APPROVED FOR

ACCOUNTING CLASSIFICATION *(Appropriations Symbol must be shown; other classification optional.)*

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CERTIFICATE OF DEPENDENCY

A certificate of dependency is required for a dependent spouse; dependent natural, step, and adopted children; dependent parents; dependent children over 21 years of age who are mentally or physically incapacitated; and unmarried dependent children who are under 23 years of age and are or will be attending a school in the United States for the purpose of obtaining a secondary or undergraduate college education.

CERTIFICATE OF PROOF OF DEPENDENCY

I CERTIFY that my dependent(s) _____ named in this claim (reverse side)

(Relationship)

is /are in fact dependent upon me and that evidence of dependency has been filed on appropriate forms and accepted by proper authority.

NOTE: In case of a dependent parent,the certificate of dependency must be approved annually.

SIGNATURE OF OFFICER	DATE *(mm/dd/yyyy)*

ADDITIONAL CERTIFICATE OF RESIDENCE OF PARENT

I CERTIFY that my dependent(s) _____ resided as a member of my

(Relationship)

household at the time of receipt of applicable orders other authority and resided as a member of my household established incident to the change of station.

SIGNATURE OF CLAIMANT	DATE *(mm/dd/yyyy)*

ADDITIONAL CERTIFICATE FOR STEPCHILD(REN)

I CERTIFY that _____ , the mother/father of the stepchild(ren)

(Mother's/Father's Name)

named in this claim was my legal spouse at the time this travel was performed.

SIGNATURE OF CLAIMANT	DATE *(mm/dd/yyyy)*

ADDITIONAL INFORMATION *(This space may be used by claimant for any additional information which is necessary in settlement of this claim.)*

Privacy Act Statement for Voucher for Reimbursement for Travel Dependents of PHS Commissioned Officers Form PHS-2988

This statement is provided pursuant to the Privacy Act of 1974 (5 U.S.C. 552a). Our authority to collect this information is 37 U.S.C. 403; 42 U.S.C. 202 et seq.; and Executive Order 9397, "Numbering System for Federal Accounts Relating to Individual Persons."

The information provided is used to certify the dependency status of the persons for whom travel reimbursement is requested. The other uses which may be made of this information are described in the system notice for records system 09-37-0002, "PHS Commissioned Corps General Personnel Records, HHS/OASH/OSG." A copy of this system notice may be obtained from the office to which you submit this form.

Disclosure of Social Security Number (SSN) is mandatory. The SSN is requested for identification purposes. Failure to supply complete and accurate information may result in denial of request.