FORM OF APPLICATION FOR CLAIMING REIMBURSEMENT OF MEDICAL EXPENSES OF GOVERNMENT SERVANTS

(Separate Form should be used for each patient)

1.	Name & Designation of Government Servant (In Block letters)	:
2.	Pay and scale of pay	:
3.	Office in which employed	:
4.	Place of duty	:
5.	Residential Address	:
6.	Name of patient and relationship of the Government Servant to the patient	:
7.	Place at which the patient fell ill	:
8.	Whether hospitalized or not	:
9.	If hospitalized, whether in Government Hospital or Private (notified) Hospital and the name of Hospital.	:
10.	If hospitalized, outside the State	:
	i. Whether the patient was on duty	:
	ii. Name of Institution	:
11.	If on special treatment outside the State	:
	i. Name of institution	:
	ii. Whether prior sanction of Director of Health Services has been obtained	:
12.	Last date of treatment	:
13.	Charges: (Details of amount claimed, list of medicines, cash memos and essentiality certificate should be attached)	
	i. Charges for medicines	:
	ii. Charges for treatment	:
	iii. Charges for accommodation	:
	iv. Charges for diet	:
14.	Total amount claimed (in figures and words)	:
15.	List of enclosures	
	i.	
	ii.	
	iii.	

Declaration to be signed by the Government Servant

I hereby declare that the statement given above are true to the best of my knowledge and belief and that person for whom medical expenditure has been incurred is wholly depended on me.,

Place :
Date :

Signature of Government Servant

APPENDIX I
FORM OF ESSENTIALITY CERTIFICATE

I certify that Sri./Smt. . . . . employed in the College of Fisheries, Panangad department has been under treatment of this Hospital/dispensary or at his her residence for the period from . . . . to . . . . and that the under mentioned medicine prescribed by me in this connection were essential for the recovery prevention serious deterioration in the condition of the patient. They do not include proprietary preparations for which cheaper substance of equal therapeutic value are available not preparations which are primary food, tonic, toilet preparations or disinfectants.

It is certified that the case did not required hospitalization but is one of prolonged nature requiring medical attendance at the out patient department spreading over a period of more than 10 days.

The patient was/has been suffering from . . . . (names of disease).

Date	Bill No.	Trade/Brand Name of Medicine	Chemical/Pharmacological Name of Medicine	Price (Rs.)	Amount (Rs.)

(*Signature with Date*)
Name & Designation of the Authorized Medical Attendant

(Office Seal)

Date	Bill No.	Trade/Brand Name of Medicine	Chemical/Pharmacological Name of Medicine	Price (Rs.)	Amount (Rs.)

(*Signature with Date*)
Name & Designation of the Authorized Medical Attendant

(Office Seal)

DECLARATION

I, ………………………………………………employed in the **KUFOS, Panangad** hereby declare that …………had been under treatment at **……………………………………** **(Name of Hospital)** during the period of treatment **from …………………to ………………………** and I have received the benefit of only one system of treatment and not taken advantage of more than one system simultaneously.

Signature :

Place : Name :

Date : Designation :