APPENDIX – 5

(see sub-rule 12 of rule-40)

Performa for details of Family

Name of Government Employee : ……

Designation : ……..

Date of Birth : …….

Date of Appointment : …….

Details of member of my Family :-

Sl. no.	Name of members of Family	Date of Birth	Relationship with Govern	Initial of Head of Department/Office	Remarks

I hereby undertake to keep the above particulars upto date by notifying the Head of Officer any addition or alteration.

Place : Signature of Government Employee

Date :

Appendix - I
(See Rule 7 (4))

FORM OF APPLICATION FOR MEDICAL CLAIMS

Form of application for claiming reimbursement of medical expenses in connection with medical attendance/treatment of Sikkim Government servants and member of their families as out patients in the Hospitals.

(N.B.:- Separate form should be used for each patients)

1. Name & Designation of Government Servant.
   (In block letters)
2. Whether married or un-married.
3. If married the place where wife/husband is employed.
4. Office which employed.
5. Pay of the Government Servant.
6. Actual Residential Address.
7. Name of the patient his/her relationship to the Government Servant. (N.B in the case of children state age also).
8. Place of duty.
9. Place in which the patient fell ill.
10. Nature of illness and duration.
11. Amount claimed.
12. List of enclosures.

DECLARATION TO BE SIGNED BY THE GOVERNMENT SERVANT

I hereby declare that the statements in this application are true to the best of my knowledge and belief and that the person for whom medical expenses were incurred is wholly dependant upon.

Date.....

Signature of the Government servant and name office to which attached.

I Dr.....hereby certify that the patient is/was suffering from.....is/was under my treatment from.....to..... and that the under mentioned and medicines prescribed by me in this connection were essential for the treatment of the patient. These medicines do not include proprietary preparations for which cheaper substances of equal therapeutic value are available nor preparations, which are primarily foods. Toilets or disinfection. The medicines are not stocked in the .....name of hospitals

	Name of Medicines	Price	Name of Medicines	Price
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				

Date.....

Signature of Medical Officer

CERTIFICATE OF CONTROLLING OFFICER

Certified that I have after scrutiny of the claim as required under rule 21 satisfied myself that the claim is to the best of my knowledge and belief correct.

_____

SGPS-8/Sty./20,000-30.5.2001

Signature and Designation