INDIAN SIGN LANGUAGE RESEARCH AND TRAINING CENTRE

Module No.403-406, 4th Floor, NSIC Business Park, Okhla Industrial Estate,
New Delhi - 110020

FORM OF APPLICATON FOR CLAMING REFUND OF MEDICAL EXPENSES IN CONNECTION WITH MEDICAL ATTENDANCE AND/OR TREATMENT OF CENTRAL GOVT. SERVANTS AND THEIR FAMILIES.

Authority :- Appendix VII Central Services (Medical Attendance)

N.B :- Separate Form should be issued for each patient.

1. Name and designation of Govt. servant (in block letters) :
2. Section in which employed :
3. Pay of the Govt. servant as defined in the Fundamental Rules and any other emoluments which should be shown separately :
4. Place of duty :
5. Actual Residential Address :

6. Name of the patient and his/her relationship to the Govt. servant (in case of children state also) :
7. Place at which patient fell ill :
8. Detailed of amount claimed: :
   a. Medical Attendance Fee for consultation indicating the name & designation of the Medical Officer consulted and the Hospital or Dispensary to which attached. :
   b. The number & date of the consultations and the fee paid for each consultation. :
   c. The number of injection and the fee paid for each injection. :
   d. Whether the consultation were at the consulting room of Medical officer or at the residence of the patient. :
   e. Charges for pathological or other similar test undertaking during the diagnosis. :
9. Cost of the Medicine Purchased :
10. Total amount claimed :

11. List of enclosures :

TO BE SIGNED BY THE GOVERNMENT SERVENT

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

2. It is certified that no. Govt. Fair shops/co-operative/consumer stores/drug store or run by the Central or State Govt. of local bodies or any other organization recognized under the co-operative societies act existing within radius of 2 kilometers from a place of residence and I am not residing in the area covered by CGHS.

3. It is certified that my patient/father/mother/son/daughter/wife/depended upon me and resides with me. His/Her income from all sources including pension before commutation does not exceed Rs. 3500/-. I have no earning brothers.

4. I certified that my wife is not a Govt. servant nor she has any other source of income.

Date:

(Signature of the Govt. Servant)

Office to which attached _____

_____Section_____

_____A/c No._____

Certified that the claim been scrutinized with reference to the relevant orders and instructions issued from time to time and claim appears to be genuine.

No. _____ Dt._____

Counter Signed.

Accounts Officer (Fys)
Receive Payment
Rs._____

Rupees _____for payment by including in the establishment pay bill

Name of the Bank……Branch…… SB A/C No……

Branch MICR Code…… Tel.No. of Bank Branch……

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ESSENTIAL CERTIFICATE – 'A'

Certificate granted to Mr./Mrs./Miss/Kumari _____

father/ mother/son/wife/daughter of Mr./Mrs./Miss/ Kumari _____

employed in the Indian Sign Language Research and Training Centre:-

CERTIFICATE – 'A'

a) I, Dr. _____hereby Certified that I charged and received Rs. _____for consultation on _____at my consulting room / at the residence of the patient.

b) That I charged and received Rs. _____ for administering intra-campus /intramuscular/ sub-cutaneous injections on _____ at my consulting room / at the residence of the patient.

c) That the injection administered were / were not for immunising or prophylactic purposes.

d) That the patient has been under treatment at _____ hospital / my consulting room and that the under mentioned medicines prescribed by me in this connection were essential for the recovery/ prevention of serious deterioration in the condition of the patient. The medicines are not stocked in the_____ for supply to private patient and do not include proprietary preparations for which cheaper substitute of equal therapeutic value are available nor preparations which are primarily foods, toilets or disinfections.

Name of Medicines [in block letter]		**Amount** [₹]	**Name of Medicines** [in block letter]		**Amount** [₹]
1			**6**		
2			**7**		
3			**8**		
4			**9**		
5			**10**		
Total			**Total**		

e) That the patient is / was suffering form _____ and is / was under my treatment from _____ to _____.

f) That the patient is / was not given prenatal or post natal treatment.

g) That X-ray, Laboratory test etc. for which an expenditure of Rs. _____ was incurred was necessary and were undertaken on my advice at _____.

h) That I referred that patient to Dr. _____ for specialist consultation and the necessary approval of the Director of Health Services, West Bengal as required under the rules was obtained.

i) That the patient did not requires / required hospitalization.

Date : _____

_____
[Signature and designation of the medical officer & the Hospital/ Dispensary to which attached]

Registration No._____

N.B.

Certificate not applicable would be struck off.
Certificate is compulsory and must be filled in my the Medical Officer

MEDICAL CERTIFICATE

Signature of Applicant……..

I, Dr. …….. after careful personal examination of the case hereby certify that Dr./ Shri/ Smt./ Ms. …….(name & designation of applicant) of the Office of the …….whose signature is given above is suffering from …….. and, therefore, I consider, that a period of absence from duty from…….. to ……..with effect from …….. is absolutely necessary for the restoration of his/ her health.

Place: Signature of Government Medical Officer/ Civil Surgeon/ Staff Surgeon/ Authorized Medical Attendant/ Registered Medical Practitioner alongwith official seal

Date: Registration No. _____

……..

FITNESS CETIFICATE

Signature of Applicant……..

I, Dr. …… do hereby certify that I had carefully examined Dr./ Shri/ Smt./ Ms. …… (name & designation of applicant) of the Office of the …….. whose signature is given above, and find that he/she has recovered from his/her illness and is now fit to resume duties in Government service. I also certify that before arriving at this decision, I have examined the original medical certificate and statement of the case (or certified copies thereof) on which leave was granted or extended and have taken these into consideration in arriving at my decision.

Place: Signature of Government Medical Officer/ Civil Surgeon/ Staff Surgeon/ Authorized Medical Attendant/ Registered Medical Practitioner alongwith official seal

Date: Registration No. _____