FORM OF APPLICATION FOR CLAIMING REFUND OF MEDICAL EXPENSES IN CONNECTION WITH MEDICAL ATTENDANCE AND OR TREATMENT OF CENTRAL GOVERNMENT SERVANTS AND THEIR FAMILIES FOR MEDICAL ATTENDANCE BY AUTHORISED MEDICAL ATTENDANCE

1. Name and designation of Govt. Servant (in Block Letters) :
2. Office/Section/Division/Unit in which employed :
3. Pay of Govt, servant defined in the F.R. and any other employment, which should be shown separately. :
4. Place of Duty :
5. Actual Residential Address :
6. Name of the patient and his/her relationship with Govt. Servant
   N.B. : In case of children state age also :
7. Place at which the patient ill :
8. Details of the amount claimed :
9. MEDICAL ATTENDANCE :

   (I) Fees for consultation

   a) The name and designation of the Medical Officer / Authorized Medical Attendant consulted and the hospital or dispensary or clinic to which attached :

   b) The number and date of consultation (s) and the fee paid for each consultation. :

   c) The number and date of injection (s) and the fee paid for each injection :

   d) Whether consultations / or injections (s) were had at the hospital / at the consulting room of the Medical Officer. :

   (II) Charge for pathological bacteriological, radiological or other similar tests undertaken during diagnosis indicating :

   a) The name of the hospital / or laboratory where undertaken and :

   b) Whether the tests were undertaken on the advice of the authorized medical attendant. If so a certificate to that effect should be attached. :

10. Costs of medicine purchased from the market :

11. Total amount claimed :

12. Less advance taken :

13. Net amount claimed :

14. List of enclosures :

DECLARATION TO BE SIGNED BY THE GOVERNMENT SERVANT

I do hereby declare that the statements made 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 dependent upon me.

Date : ....

Signature of the Government Servant.

Certificate granted to Mr. / Mrs. / Miss ______________________________

______________________ Wife / Son / daughter of ______________________

______________________ employed in the ______________________

CERTIFICATE 'A'

(To be completed in the case of patients who are not admitted to hospital for treatment)

a) I, Dr, ______________________ hereby certify that I charged and received Rs.______________________ for consulation on ______________________at my consulting room at the residence of the patient.

b) That I charged / received Rs. ______________________ for ______________________ intramuscularly injections / or subcutaneous from __________

c) That the injections administered were/ were not immunisning or prophylactic purposed.

d) That the patient has been under my treatment at ______________________ ______________ hospital and that the under mentioned medicined 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 ______________________ for supply to private patients and to do not include propritory preparations for which cheaper substances of equal therapeutic value are available nor preparations which are primarily foods, toilets or disinfectants.

NAME OF MEDICINE (IN BLOCK LETTERS)	**PRICE**

e) That the patient is / was suffering from ______________________________

(IN BLOCK LETTERS)

and is / was under my treatment from ____________________ to ____________________

f) That the patient is / was not given pre-netal or post-netal treatment.

g) That the X-ray, laboratory tests, etc, for which an expenditure of Rs. ______________ was incurred were necessary and were undertaken on my advice at ______________________

______________________________(Name of hospital or laboratory)

h) That I referred that patient to Dr. ______________________________

for specialist consulation and that the necessary approval of the ______________________

____

(Name of the Chief Assistant Medical Officer)

as required under the rules was obtained.

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

Date

Signature and Designation of the
Medical Officer of the Hospital
Dispensary to which attached.

N.B. : Certificate not applicable should be struck off.
Certificate is compulsory and must be filled in by
the Medical Officer in all cases.