

ERP NO..... SB/AC.....Mob. No.....

FORM OF APPLICATION FOR CLAIMING REFUND OF MEDICAL EXPENSES IN CONNECTION WITH
MEDICAL ATTENDANCE OR TREATMENT OF CENTRAL GOVT. SERVANT AND THEIR FAMILIES
N.B. Separate form should be used for each patient.

1. Name & Designation of the Govt.

Servant (in block letters)

i. Whether married or unmarried

ii. If married the place where wife
husband is employed

2. Office in which employed : Indian Institute of Sugarcane Research, Lucknow.

3. Pay of the Govt. Servant Rs. _____ /- plus allowances.

4. Place of duty I.I.S.R.- Lucknow

5. Actual Residential Address :

6. Name of the patient and
his/her relationship to the :
Govt. Servant

N.B. In the case of children state age also.

7. Place of illness and its duration:

8. Nature of Disease :

9. Details of the amount claimed

i.(a) Fee for consultation indication name &
designation of the Medical officer consulted
and the hospital or dispensary to which attached.

(b) the Nos. and dates of consultation and
the fee paid for each consultations.

(c) The nos. and date of injection and
the fee paid for each injection

ii. Cost of medicines purchase from the
market list of medicines purchased from
the market cash-memo and the essential
certificate attached.

10. Total amount claimed

11. List of enclosures.....

DECLARATION TO BE SIGNED BY THE GOVERNMENT SERVANT

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

2. I.....hereby declare that in case of my death, amount of this claim shall be paid to
Mr.....who is myand his/her

Address is.....
.....

Dated :

Signature and date of the Govt.
Servant and office to which attached

Certificate granted to Mr./Mrs./Miss.....
wife/Son/Daughter/Mother/Father or Brother of.....
employed in the Indian Institute of Sugarcane Research, Lucknow.

CERTIFICATE

(To be completed in the case of patients who are admitted in hospital for treatment)

1. (a) I, Dr. hereby certify that I charged and received Rs. (Rupees) for..... consultation on dated to be given at my consulting room outside hospital hours/at the residence of the patient.

(b) That I charged and received Rs..... Rupees (.....) on date to be given) at my consulting room/outside hospital hours/the resident of the patient.

(c) that the injection administered were for/where not immunizing or prophylactic purposes.

(d) That the patient has been under treatment at hospital/ my consulting room and that 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 in the stocked do not include proprietary preparations for which cheaper substances of equal therapeutic value are available for preparation with the priparily foods toilers or disinfectants.

Sl.No.	Name of the medicines (Block letters)	Rs.	Paise.
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.....
(e) that the patient is/was suffering from..... and is/was under my treatment from..... to.....

(f) That the patient is/was not given prematal of post matal treatment.

(g) that the X-ray laboratory tests etc. for which in expenditure of Rs. (Rs._only) was incurred were hospitary and were undertaken on my advice at.....

(h) that I referred the patient to Dr. for specialist consultation and that necessary approval of (name of the Chief Administrative Medical Officer of the State) as required under that rule was obtained.

Certified that the medicine have been purchased from authorised medical Dealer/shops.

Dated :

Signature and designation of the
Medical Officer and the Hosp/Disp./to which attached