

INDIAN SIGN LANGUAGE RESEARCH AND TRAINING CENTRE

Module No.403-405, 4th Floor, NSIC Business Park,
Okhla Industrial Estate, New Delhi- 20

**FORM OF APPLICATION FOR CLAIMING 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 whom 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.....

INDIAN SIGN LANGUAGE RESEARCH AND TRAINING CENTRE
A- 91, 1st floor, Nagpal Business Tower, Okhla Phase II, New Delhi

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 thewhose signature is given above is suffering from and, therefore, I consider, that a period of absence from duty from..... towith 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. _____

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FITNESS CERTIFICATE

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. _____