

FORM OF APPLICATION

See Rule 8 (1)

N.B. Separate Form Should be used for each Patient)

- 1- Name and designation of the Government Servant.....
in block letters)
- 2- Office in which employed.....
- 3- Pay of the Government Servant as defined in the
Fundamental Rule 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
of the Government servant.....
(N. B-In the case of children, give the following information, Namely
(state age also)
 - i) Total No. of Children alive
 - ii) Date of birth
 - iii) Serial No. of the children
- 7- Place which the patient fell ill.....
- 8- Nature of illness and its duration.....
- 9- Details of the amount claimed.....
 - 1- Medical attendant
 - i) Fees for consultation Including-
 - (a) The Name and designation of the Medical
Officer consulted and the hospital or dispensary to which attached.
 - b) The number and dates of consultations
and the fees paid for each consultations
 - (c) Whether consultation were held at the
hospital at the consulting room of the
medical officer or at the residence of the patient.
 - ii) Charges for Pathological, Bacteriological.
Radiological or other similar teste under taken.
during diagnosis indicating-
 - a) The name of the hospital of laboratory
where the test were under taken, and
 - b) Whether the tests were under taken, on the
advice of the authorised medical attendant.
and if so, a certificate to that effect
should be attached.
 - iii) cost of medicines purchased form the market.
(List of medicines, cash memo, and the essentiality certificate should be
attached).

2- Hospital treatment-

Charges for hospital treatment indicating separately the charges for-

- 1- Accommodation (State whether it was according to the status or pay of Government servant and in cases where the accommodation is higher than the status of the Government servant a Certificate should be attached to the effect that the accommodation to which he was entitled was not available.

Diet.....

3- Surgical operation of medical treatment.....

4- Pathological bacteriological radiological or other.....
similar tests indicating-

a) The name of the hospital or laboratory at.....
which under taken and

b) Whether undertaken on the advice of.....
medical officer incharge of the case at the
hospital if so a certificate to that effect should
be attached

5- Medicines.....

6- Special medicines.....

(List of medicines cash memo, and the essentiality
certificate should be attached)

7- Ordinary Nursing.....

8- Special Nursings, Nurses specily engaged for the
patient State whether they were employed on the
advice of the medical officer incharge of the case at the
hospital or at the request of the Government servant or
patient in the former case a certificate from the M O / C
of the case one countersigned by the Medical Superin-
tendent of the hospital should by attached.

9- Any other charges i eg charges for electric Light, fan
heater air conditioning etc. State also whether the
facilities referred to are a part of the facilities normally
provided to all patients and no choice was left to the
patients.

Note- If the treatment was received by the Government servant at
his residence give Particulars of such treatment and attach
a certificate from the authorised medical attendent.

10- Total amount claimed Rs.....

11- List of enclosures.....

Declaration to be Signed the Government Servant

I here by declare that the statements in his application are true to the best of my
knowledge and belief and that the person for whom medical expences were incurred
wholly dependent upon the Further that the medicines for which the claim is submitted
have been purchased from the shops approved by the Govt. for the sector in which reside
and where so purchased non availability certificate duly issued by the approved shop is
are enclosed with this claim

Date.....

.....
Signature of Government Servant
and office which attached.

FORM II
FORM OF ESSENTIALITY CERTIFICATE

See Rule 8 (1)

A-In Case of medicine not included in the period vocabulary of medical stores Depot.

CERTIFIED that Shri/Smt/Kumari..... Son/Wife/
Daughter of Shri..... employed in the.....
has been under my treatment from..... to.....
For..... (Name of the disease) at the.....

hospital as an indoor/outdoor patient and that the undermentioned medicines have been prescribed by me in this connection are not included in the period vocabulary of the Medical Stores These medicines were absolutely essential for treatment of the a foresa ad patient,

Varified that the medicines has been purchased from the shop approved for the sector in which Shri/Smt/Kumari..... resides and wherever not so put chased non availability duly certificates issued by the approved shop has/have enclosed.

| Name of Medicines | Cost |
|-------------------|-------|
| (1) | (2) |
| 1- | |
| 2- | |
| 3- | |
| 4- | |
| 5- | |
| 6- | |
| 7- | |
| 8- | |
| 9- | |
| 10- | |

Signature and designation of the authorised medical attendant
Signature of the Medical Officer I/C of the Case at the hospital

B-In case of medicines included in the priced vocabulary of medical store Depot I/CERTIFY that
Shri/Smt/Kumari.....
Son/Wife/Daughter of Shri.....
employed in the (Name of the disease)
has been under my treatment for
at the hospital from to.....
as an indoor/outdoor patient and the undermentioned medicine have been prescribed by me in this connection These medicines are out of stock/not available in the.....
hospital. They donot included any medicines proprietary of otherwise out side the aforesaid priced vocabulary not are the preparations which are primarily food, toilets of disinfectants).

Varified that the medicines have been purchased from the shop approved for the sector in which Shri/Kumari... resides and when ever not so purchased non availability certificate/duly issued by the approval shop have enclosed.

| | Name of Medicines (1) | P.V.M.S. No. (2) | Cost (3) |
|-----|--------------------------|---------------------|-------------|
| 1- | | | |
| 2- | | | |
| 3- | | | |
| 4- | | | |
| 5- | | | |
| 6- | | | |
| 7- | | | |
| 8- | | | |
| 9- | | | |
| 10- | | | |

Signature and designation of the authorised medical attendant
Signature of the Medical Officer I/C of the Case at the hospital

C-In Case of Insulin Treatment

CERTIFIED that Shri/Smt./Kumari.....
Son/Wife/Daughter of Shri..... employed in the has
been under my treatment for diabetes at my hospital from..... to.....
and that insuline prescribed by the.....
was for treatment during the initial stage in the hospital of the disease for which no reimbursement
has been made extending over the period from.....
the patint having developed complications necessitating hospitalisation.

Authorised Medical Attendent/Medical
Officer I/C of the Case of Hospital