Indian Institute of Technology Kanpur

FORM OF APPLICATION

P.F. No./ Roll No .: ....

Tel .: ....

Bank Name .: ....

Account No .: ....

---

1. Name, Designation, Department

---

2. Pay as defined in fundamental Rules Rs.

---

3. Actual residential address

---

4. Name of the patient and his/ her relationship to the employee (in the case of children state age also) and the place patient fell ill

5. Details of the amount claimed :
   i) Medical Attendance :
      a) Name and designation of the Medical Adviser
      b) Number and dates of consultation and fee paid for each consultation injection

   ii) Consultation with specialist
      a) Name and designation of the specialist

      b) Number and dates of consultation and fee paid for each consultation.

   iii) Charges for pathological bacteriological test :
      a) Name of hospital Lab. where undertaken.

      b) Whether undertaken on the advice of Medical Adviser/ Medical Officer.

   iv) Cost of Medicines Cash Memo(s) to be attached :

6. Total amount claimed Rs. ....

7. Less Advance taken Rs. ....

8. Net amount claimed Rs. ....

9. List of enclosures (i) .... (ii) .... (Iii) ....

DECLARATION

1. I hereby declare the statement 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.

2. Certified that my father is not an earning member. He is wholly DEPENDENT upon me and is residing with me.

3. Certified that my FATHER is not an earning member and my MOTHER is WHOLLY DEPENDENT upon me. She is also residing with me.
   N. B. -Certified not applicable should be scored out.

Dated..........................20 **SIGNATURE OF EMPLOYEES /STUDENT**

Indian Institute of Technology Kanpur

CERTIFICATE- A

P. F. No./Roll No .: ....

Tel .: ....

Bank Name .: ....

Account No .: ....

Certificate granted to Shri/Smt./Kumari ....
(Indicate relation) .... of Shri/ Dr ....
I, Dr .... hereby certify

1. That I charged and received Rs .... (Rupees ....
   only) for .... consultations on .... at my consulting room at the residence of the patient after hospital hours.
2. That the patient has been under treatment at ....
   hospital/ my consulting room and the under mentioned medicines by me in this connection were essential for the recovery/ prevention of serious deterioration in the condition of the patient. These medicines were not stock in the I.I.T.Kanpur hospital for supply to private patient and do not include proprietary preparation for which cheaper substance / substances of equal therapeutic value are available nor preparation which are primarily foods, toilets or disinfectants.

NAME OF MEDICINES

(IN BLOCK LETTERS)

S. No.	Name	Qty.	Amount	R or NR*	S. No.	Name	Qty.	Amount	R or NR*

R = Reimbursable, NR = Non-Reimbursable*

3. That the patient is/was suffering from .... and is/was under my treatment from ....to...
4. That the X-ray, Laboratory test etc. dated .... for which expenditure of Rs .... was incurred were necessary and were undertaken on my advice, due to their non availability of Health centre.
5. That I referred the patient to the .... hospital which is the nearest entitled Hospital from the place where the patient fell ill which in my option could provide the necessary and suitable treatment.
6. That I referred the patient to Dr .... Specialist M. O. in Government employment in the .... for Specialist consultation.

Date 20

Signature and Designation of the
Medical adviser / Medical Officer

(For use in the Accounts Section)

S. No. ....

Date ....

(a) Total amount of claim passed (Rs.) ....

(b) Less advance drawn, if any (Rs.) ....

(c) Net amount payable/ recoverable (Rs.) ....

Checked by ....

Claim Prepared by ....

Please Pay Rs .... (Rupees ....
....)

Assistant Registrar

Deputy Registrar

Registrar