

EMPLOYEE CODE :

SREE CHITRA TIRUNAL INSTITUTE FOR MEDICAL SCIENCES & TECHNOLOGY
Application for Medical Reimbursement under CS (MA) Rules

- 1 Name of the Employee (in block letters) :
- i. Designation :
- ii. If married , the place where husband / wife employed :
- 2 Place of Duty :
- 3 Pay of the employee (Basic pay) :
- 4 Actual residential address :
- 5 i Name of the patient :
- ii Relationship with employee :
- iii Age :
- 6 Place at which the patient fell ill :
- 7 MEDICAL ATTENDANCE DETAILS
- (a) Name of the Medical Officer consulted,
Designation and Hospital :
- (b) Dates of consultations and
Fee paid for each consultation :
- (c) Dates of injection taken (with no.)
Fee paid for injection :
- (d) Where the consultation / injections had : (Staff clinic / Approved
Hospital / Consultants
residence).
- 8 Total amount claimed : Rs.
- 9 List of enclosures :

(if space is not sufficient, separate statement to be attached)

DECLARATION TO BE SIGNED BY THE EMPLOYEE

I hereby declare that the statements 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.

I also declare that no Co-operative Medical Store is available within two kilometers from my residence.

Date : Signature of the Employee

Received the payment of Rs..... (Rs.....
.....) as per the claim over leaf.

Signature of payee with date
Name and Designation

ESSENTIALITY CERTIFICATE GRANTED TO

Mr/ Miss/ Mrs.....Son/Daughter/Husband/Wife/Father/Mother of
Mr/ Miss/ Mrs.....employed in SCTIMST, Tvm-11.

CERTIFICATE – A (for OP treatment only)

Drhereby certify

- (a) that I charged and Received Rs.....for.....consultations
onat my consultation room/residence of the patients.
- (b) that I charged and received Rs.....for.....administering
intra-venous / intra-muscular / subcutaneous injections on.....
at my consulting room/ residence of the patient.
- (c) that the injection (s) administered was / were not for immunizing or prophylactic purpose.
- (d) that the patient has been under treatment at
Hospital / my consulting room and that the medicines mentioned here under prescribed by me
were essential for the recovery / prevention of serious deterioration in the condition of the patient.

The medicines are not stocked in the.....Hospital for supply to private patients and do not include proprietary preparation for which cheaper substances of equal therapeutic value are available for preparations which are primarily foods, toilets or disinfectants.

[illegible]

Total

(if space is not sufficient attach separate statement)

- (e) that the patient is / was suffering from.....
and is / was under my treatment from.....to.....
- (f) that the patient is / was not given pre-natal treatment.
- (g) that the X-ray Laboratory test etc. for which an expenditure of Rs.....
was incurred were necessary and were under taken on my advice at.....
(name of Hospital / Laboratory).
- (h) that I referred the patient to Dr..... for
special consultation.

Date & Seal

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

NB : Certificate (s) not applicable should be struck off.

OBVSERVATIONS OF ACCOUNTS DIVISION

Verified the claim. May be passed for Rs.....

Medical Supt.

AMO

Accounts Officer

Assistant