COLLEGE OF HORTICULTURE AND FORESTRY

CENTRAL AGRICULTURAL UNIVERSITY, PASIGHAT – 791 102, ARUNACHAL PRADESH
Ph: 0368 – 2224887 Fax: 0368 – 2225066 e-mail: chfdeanpsg@gmail.com, chfdeanpsg@yahoo.com

FORM OF APPLICATION FOR RE-IMBURSEMENT OF MEDICAL TREATMENT EXPENSES

1. Name & Designation of the Officer/employee (In block letter) : ______________________________

2. Office in which employed and place of duty : ______________________________

3. Pay as defined in Fundamental rules & any other Emoluments, which should be shown separately. : ______________________________

4. Actual residential address : ______________________________

5. Name of the patient and his/her relationship to the University Officer. (In case of children, state age also) : ______________________________

6. Place at which patient fell ill : ______________________________

7. Nature of illness and its duration : ______________________________

8. Details of amount claimed;
   1. Fees of consultation/attendance : ______________________________
   2. Charged for Pathological, radiological Bacteriological or other similar test Undertaken during diagnosis. : ______________________________
   3. Cost of medicines purchased from the market (List of medicines, cash memo and essentiality Certificates should be attached) : ______________________________

9. Total amount claimed : ______________________________

10. List of enclosures/Cash memos : ______________________________

DECLARATION TO BE SIGNED BY THE UNIVERSITY OFFICER EMPLOYEE (CLAIMED)

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 in wholly dependent upon me.

Date : ………………..

Signature & designation of the claimant
Name ………………………………….

Certificate granted to Mr./Ms………………………………………………………… wife/son/daughter of Shri/Smti……………………………………….. employed in the College of Horticulture & Forestry, Pasighat.

C E R T I F I C A T E – 'A'

(To be completed in the case of patients who are not admitted to hospital for treatment)

1. Dr. ……………………………………………………………… hereby certify that;

a) I charged and received Rs. ……………………….. for consultation on ………………… ………………… at the residence of the patient.

b) I charged and received Rs. ………………………… for administering intra-venous/intra-muscular/sub-crustaceous Injection on …………………………………………….. at my Consulting room/at residence of the patient (date to be given).

c) The injections administered were/were not for immunizing or prophylactic purposes.

d) 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 ………………………………… (Name of hospital) for supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic value and available nor preparations which are primarily foods toilets of disinfectants.

Sl. No.	*Name of Medicines*	*Price*	
		Rs.	*P.*

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 or post-natal treatment.

g) That the X-Ray, Laboratory tests etc. for which an expenditure of Rs. ………………… was incurred were necessary and were undertaken on my advice at …………………… (Name of Hospital or Laboratory).

h) That I referred the patient to Dr. ……………………………………………. For specialist consultation and that the necessary approval of the ……………………………………… (Name of the Chief Administrative Medical Officer) as required under the rules was obtained.

i) That the patient did not required/required hospitalization.

Date ……………………….

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

N.B. *Certificates not applicable should be truck. Certificate (A) is compulsory and must be filled in off by the Medical Officer in all cases.*

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DECLARATION TO BE SIGNED BY THE UNIVERSITY OFFICER EMPLOYEE (CLAIMED)

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 in wholly dependent upon me.

Date : ………………..

Signature & designation of the claimant
Name ………………………………….

CERTIFICATE 'B'

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

Certificate granted to Mrs./Mr./Miss . . . . wife/son/daughter of Mr. . . . . employed in the . . . .

PART – A

1. Dr. . . . . hereby certify :

(a) that the patient was admitted to hospital on the advice of . . . . (name of the Medical Officer)/on my advice:

(b) that the patient has been under treatment at . . . . 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 . . . . (name of the hospital) for supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available nor preparations which are primarily foods, toilets or disinfectants ;

	Name of medicines	Price
1.	.. . .	. . . .
2.	. . . .	. . . .
3.	. . . .	. . . .
4.	. . . .	. . . .
5.	. . . .	. . . .
6.	. . . .	. . . .
7.	. . . .	. . . .
8.	. . . .	. . . .

(c) that the injections administered was/were not for immunizing or prophylactic purposes ;

(d) that the patient is/was suffering from . . . . and is/was under treatment from . . . . to . . . . ;

(e) that the X-ray, laboratory tests, etc., for which an expenditure of Rs.. . . . . was incurred were necessary and were undertaken on my advice at . . . . (name of hospital or laboratory);

(f) that I called on Dr. . . . . for Specialist consultation and that the necessary approval of the .. . . (Name of the Chief Administrative Medical Officer of the State) as required under the rules, was obtained.

Signature and Designation of the Medical Officer
in charge of the case at the hospital

PART – B

I certify that the patient has been under treatment at the . . . . hospital and that the service of the special nurses for which an expenditure of Rs. . . . . was incurred, vide bills and receipts attached, were essential for the recovery / prevention of serious deterioration in the condition of the patient.

Signature of the Medical Officer
in charge of the case at the hospital

COUNTERSIGNED

Medical Superintendent
. . . . Hospital

* I certify that the patient has been under treatment at the . . . . .Hospital and that the facilities provided were the minimum which were essential for the patient’s treatment.

Medical Superintendent
. .. . Hospital