

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) (lii)

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

