SBI ACCOUNT NO.	Chargeable head:	
	01(h) Reimbursement of	
	Medical Expenses.	
	Passed for Rs.	

Dealing Assistant DR(F&A) Registrar

NATIONAL INSTITUTE OF TECHNOLOGY, HAMIRPUR (HP).

FORM OF APPLICATION FOR CLAIMING OF MEDICAL EXPENSES INCURRED IN CONNECTION WITH MEDICAL ATTENDANCE TREATMENT OF THE EMPLOYEES AND OTHER FAMILY MEMBERS OF NIT, HAMIRPUR

(Rupees_____

1.	Name & Designation of the Employee		
	(in Block Letters)		
2.	Office in which employed	NIT, Hamirpur	
3.	Pay of the Employee		
4.	Place of the Duty		
5.	Actual Residential Address		
6.	Name of the Patient and his/her		
	relationship to the employee		
	(Indicate age in case of Children)		
7.	Place at which the patient fell ill		
	(name of hospital)		
8.	Total amount claimed		
9.	List of enclosures		

DECLARATION TO BE SIGNED BY THE COLLEGE EMPLOYEE

I hereby declare that the statement made in the application are true to the best of my knowledge and belief and that the person for whom the medical expenses were incurred is wholly dependent upon me.

Dated: - Signature of the Employee

CERTIFICATE-B

(To be completed in case of patient who are admitted in the hospital for treatment) Certificate granted to Miss/Mr./Smt./ MrWife/Son/Father/Mother/Daughter / Employee of National Institute of Technology, Hamirpur(HP)-177001						
Part-A (to be signed by the Medical Officer Incharge of thecase of the hospital) I, Dr						
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 the private patients and do not include proprietary preparation for which cheaper substances of equal therapeutic value are available nor preparation which are primarily food, toilets or disinfectants.						
Sr. No.	Name of the Medicine	Amount	Cash Memo No. & Date	Name of the Dealer		
110.			110. & Date			
d) Th	at the injections administered were/what the X-Ray, Laboratory Tests etc. for the triple were necessary and were under the ame of hospital or laboratory).	or which ar	expenditure of	was		
e) That the patient is was suffering fromand is was under my treatment from						

PART-B

	(name of Hospital)and	
	ial nurses for which an Expenditure of	
Rs	was increvention of serious deterioration in the cond	curred vide bills and receipts attached were
essential for the recovery/p	prevention of serious deterioration in the cond	lition of the patient.
		
Dated: -	Signature of M	
Place: -	Incharge of the	e Hospital
	COUNTERSIGNED	
	Medical Superintendent	
	(Name of Hospital)	-
	s been under treatment at thelities provided were the minimum which were	
		•
Oated: - Signature of Medical Superintendent / Incharge of the Hospital		
Note: Certificate not applic		
Certificate(s) is compulsor	v and must be filled in the Medical Officer in	all cases