Dr. Y. S. Parmar University of Horticulture & Forestry
Nauni, Solan-173 230 (H. P.)

Form of Application for claiming of Medical Expenses incurred in connection with Medical and/or Treatment of University servant and their families

N.B.— Separate Form should be used for each patient

1. Name and designation of employee (in block letters) .....
2. Office in which employed .....
3. Pay of the employee (as defined in the fundamental rules and any other emoluments which should be shown separately). .....
4. Place of duty .....
5. Actual residential address .....
6. Name of the patient and his/her relationship to employee (in case of children, *state* age also) .....
7. Place at which the patient fell ill .....
8. Details of the amount claimed .....
   (*i*) Cost of medicines purchased from the market (list of medicines, cash memo and the essentiality certificate should be attached).
9. Total amount claimed .....
10. List of enclosures .....

Declaration to be signed by University employee

I hereby declare that the statements 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 dependant upon me.

Dated.....

Signature of the employee.

Certificate granted to Mr./Mrs./Miss.....wife/son/daughter of Mr.....employed in the Dr. Y. S. Parmar University of Horticulture and Forestry at .....

CERTIFICATE

To be completed in case of patients who are not admitted to hospital for treatment.

CERTIFICATE 'A'

I, Dr.....hereby certify :—

(*a*) That the patient has been under my treatment at..... and that the undermentioned medicines prescribed by me in this connection were essential for the recovery of the patient prevention of serious deterioration in this condition of the patient. The medicines are not stocked in the University Dispensary/Hospital for patients and do not include proprietory preparations for which cheaper substance of equal thereapeutic value are available nor preparations which are primarily food, toilets or desinfectants.

Sl. No.	Name of the Medicines (in Block Letters)	Price
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

(*b*) That the patient is/was suffering from.....
and is/was under my treatment from.....to.....
He did/did not require hospitalization.

Signature of Medical Officer.

N.B.—(1) Where not applicable should be struck off.
(2) Certificate (*b*) is compulsory and must be filled in by the Medical Officer.

राजकीय मुद्रणालय, हि० प्र०, शिमला–511–यू० एच० एफ० / 2006–9–6–2006–5,000.