केन्द्रीय शीतोष्ण बागवानी संस्थान
CENTRAL INSTITUTE OF TEMPERATE HORTICULTURE
(भारतीय कृषि अनुसंधान परिषद)
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Appendix-XIV

ESSENTIALITY CERTIFICATES

CERTIFICATE 'A'

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

Certificate granted to Miss/Mrs./Mr. _____

Wife/Son?Daughter of Mr. _____ employed in the _____

I, Dr ..... hereby certify:-

(a)that I charged and received Rs. _____ for _____ consultations on _____(dates to be given) at my consulting room/ at the residence of the patient;

(b) that I charged and received Rs. _____ for administering _____ intra venous/ intramuscular/ subcutaneous injections on _____ (dates to be given) at _____ my consulting room/ the residence of the patient:

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

(d) that 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 _____ (Name of 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.

S.No	Names of Medicine(s)	Price in Rs	S.No	Name of Medicine(s)	Price in Rs
1.			9.		
2.			10.		
3.			11.		
4.			12.		
5.			13.		
6.			14.		
7.			15.		
8.			16.		

(e) that the patients 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-Rayt, laboratory test, etc. for which an expenditure of Rs _____was incurred was 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 Medical Officer of the State) as required under the rules was obtained;

(i) that the patient required/did not required hospitalization.

Dated _____

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

N.B.:- Certificates not applicable should be struck off. Certificate(e) is compulsory and must be filled in by the Medical Officer in all cases.

Appendix- XIII

FORM OF APPLICATION FOR MEDICAL CLAIMS

From of application for claiming refund of medical expenses incurred in connection with medical attendance and/or treatment of Central Govt. Servants and their families for medical attendance/ treatment taken both from an Authorised medical Attendant and a hospital

1. Name and designation of Govt. Servant
(In Block Letters) :_____

2. Office in which employed :_____

3. Pay of the Govt. Servant 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 the
Govt Servant (N.B- in the case of children state age also) :_____

7. Place at which the patient fell ill :_____

8. Details of the amount claimed :_____

9. Medical Attendance :_____

(I) Fees for consultation indicating
(a) The name and designation of the Medical
Officer consulted and the hospital or
Dispensary to which attached..... :_____

(b) The number and dates of injection
and the fee paid for each injection. :_____

(c) Whether consultations and or injections
were had at the hospital, at the consulting
room of the medical officer or at the residence ot the patient: :_____

(II) Charges for pathological, bacteriological
radiological or other similar tests
undertaken during diagnosis indicating :_____

(a) the name of the hospital/laboratory
were undertaken; and :_____

(b) whether the tests were undertaken on
the advice of the authorized medical
attendant. If so, a certificate to that effect should be attached: :_____

(III) Cost of medicine purchased from the market:

10. Total amount claimed :Rs._____(Medicine Charges_____ Pathological Charges_____)

11. Less advance taken on____ : Rs._____

12. Net amount claimed :Rs._____(Medicine Charges_____pathological Charges_____)

13. List of enclosures :Rs._____

DECLARATION TO BE SIGNED BY THE GOVERNMENT SERVANT

I hereby declare that the statement in the 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.

Date:_____

Singature of Govt. Servant
and office to which attached