Form KVV-5/13

HIMACHAL PRADESH KRISHI VISHAVIDYALAYA
(See Rule 5.24 of Part-1 of the Account Manual)

FORM OF APPLICATION FOR CLAIM OF MEDICAL EXPENSES INCURRED IN CONNECTION WITH MEDICAL AND/OR TREATMENT OF HIMACHAL PARADESH KRISHI VISHAVIDYALAYA SERVANTS AND THEIR FAMILIES.

N.B. SEPARATE Form should be used for each patient.

1	Name and designation of the employee (in block letters)	:
2	Office in which employed	:
3	Pay of the employees (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 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 memos and the essentiality certificate should be attached)	:
9	Total amount claimed	:
10	List of enclosures	

DECLARATRION TO BE SIGNED BY UNIVERISTY EMPLOYEE

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

Dated : **Signature of the employee**

Certified granted to Mr./ Mrs./ Miss _____wife / son / daughter of Mr._____ employed in the CSK Himachal Pradesh Krishi Vishavidyalaya, at Palampur.

CERTIFICATE

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

CERTIFICATE A

1, Dr. _____ hereby certifies:

(a) That the patient has been under my treatment at _____ and that the under mentioned medicines prescribed by me in the connection were essential for the recover of the patient prevention of serious deterioration in the condition of the patient. The medicines are not stocked in the University Dispensary/Hospital for the patients and do not include proprietary preparations for which cheaper substance of equal therapeutic value as available for preparations, which are primarily food, toilets or disinfectants.

Sr.No.	Name of the Medicines (in block letters)	Price (Rs.)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
	Total	

(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.

i) Where not applicable should be struck off.

ii) Certificate (b) is compulsory and must be filled by the Medical Officer