

**FORM OF APPLICATION FOR CLAIMING REIMBURSEMENT OF MEDICAL EXPENSES  
OF GOVERNMENT SERVANTS AND THEIR FAMILIES**

(Separate form should be used for each patient)

1. Name and designation of Government Servant :  
(In block letters)
2. Scale of pay :
3. Office in which employed :
4. Place of duty :
5. Residential address :
6. Name of patient and relationship of the  
Government servant to the patient :
7. Place at which the patient fell ill :

**HOSPITAL TREATMENT**

8. Whether hospitalised or not :
9. If hospitalised whether in Government hospital  
or private (notified hospital and the name of  
hospital) :
10. If hospitalised outside the State
  - i) Whether the patient was on duty :
  - ii) Name of institution :
11. If on special treatment outside the State-
  - i) Name of institution :
  - ii) Whether certificate of Director of  
Health Services as contemplated in Rule 7  
(a) is attached :
  - iii) Whether prior sanction of Director of Health  
Services has been obtained :
12. Last date of treatment :

**CHARGES:-**

13. Details of amount claimed :

(List of medicines, cash memos and essentiality certificate should be attached)

- i) Treatment in Government hospital  
Medicines
- ii) Treatment in private institutions  
(Bills to be certified indicating emergency of the case)

- 1. Charges for medicines :
- 2. Charges for treatment :
- 3. Charges for accommodation :
- 4. Charges for laboratory services :
- 5. Charges for diet :

14. Total amount claimed (in figures and in words) :

15. List of enclosers-

- 1. Essentiality certificate :
- 2. List of cash bills :
- 3. Certificate of medical officers :

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**Declaration to be signed by the Government Servant**

I hereby declare that the statement given above are true to the best of my knowledge and belief and that the person for whom medical expenditure has been incurred is wholly dependent on me.

Place:

Date:

*Signature of the Government Servant.*

## FORM OF ESSENTIALITY CERTIFICATE

I certify that Shri/Smt ..... employed in the ..... has been under treatment of this hospital/dispensary or at his/her residence for the period from ..... to ..... and that the undermentioned medicines prescribed by me in this connection were essential for the recovery/ prevention of serious deterioration in the condition of the patient. They do not include proprietary preparations for which cheaper substance of equal therapeutic value are available, not preparations which are primary foods, tonics, toilet preparations or disinfectants.

It is certified that the case did not require hospitalisation but is one of prolonged nature, requiring medicine attendance at the our-patient department spreading over a period of more than 10 days.

The patient was/has been suffering from ..... (name of disease).

Trade /Brand name of medicines	Chemical/Pharmacological name of medicine	Description	Price	
			Rs.	Ps.

Name and designation of the  
Authorised Medical Attendent.

Date:

(Office Seal)

Name of Institution.