# ASSAM UNIVERSITY, SILCHAR

APPLICATION FOR CLAMING REFUND OF MEDICAL EXPENDITURE INCURRED IN CONNECTION WITH THE TREATEMENT OF THE EMPLOYEES/ FAMILY MEMBERS OF THE EMPLOYEES OF A.U.S.

1. Name and Designation of the Employee (in block letters) :
2. Office in which employed :
3. Pay of the employee FR & other emoluments which Should be shown separately :
4. Place of duty :
5. Actual residential address :
6. Name of the patient and his Relationship with the employee (NB) in case of children state age :
7. Place in which the patient fell ill :
8. Nature of illness and its duration :
9. Details of the amount claimed for :
10. a) Fees for consultation indication the name & designation of the medical officer consultation and the hospital & dispensary to which attached :
    b) No. and dates of consultation & fee paid for each consultation :
    c) Whether consulting were at the hospital or consulting room of the medical officer or at the residence of the patient :
11. Cost of medicines purchased from the market :
12. Total amount Claimed :
13. List of enclosures :

## DECLARATION TO BE SIGNED BY THE EMPLOYEE

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

Place…………………………… Signature of the employee
Date…………………………… Deptt. to which attached

*Separate from should be used for each patient.

Conted. -2

**PART-B**

I Certify that the patient has been under treatment at the……………………………… Hospital and that the service of the special nurses for which an expenditure of Rs………………………….. Was incurred, vide bills and receipts attached. Were essential for the recovery/prevention of serious deterioration in the condition of the patient.

Signature of the Medical Officer
In charge of the case at the
hospital

**COUNTERSIGNED**

Medical Superintendent
……………………………..Hospital

I certify that the patient has been under treatment at the………………………………………………………. hospital and that the facilities provided were the minimum which were essential for the patient's treatment.

Medical Superintendent

Place…………………    …………………………Hospital

Note: Certificate not applicable should struck off.
Certificate (d) is compulsory and must be filled in by the Medical Officer in all cases.

## CERTIFICATE – B

(To be completed in the case of patients who are admitted to hospital for treatment)

Certificate granted to Mrs./Mr./Miss………………………………………………………………………………………………
Wife/Son/daughter of Mr……………………………………………………………………………………………………………..
Employed in the…………………………………………………………………………………

## PART –A

I, Dr………………………………………………………………………………………….hereby certify

a) That the patient was admitted to hospital on the advice of……………………………………………………… (name of the Medical Officer)/ On my advice;

b) That the patients has been under treatment at…………………………………………………………………………….. And that the under mentioned medicines prescribed by me in this connection were essential for the recovery/preventions of serious deterioration in the condition of the patient. The medicine are not stocked in the……………………………………(name of the hospital) for supply to private patients and do not include proprietary preparations for which cheaper substance of equal therapeutic value are available nor preparations which are primarily foods, toilets or disinfectants;

| Name of Medicine | Price |
|---|---|
| 1. ………………………………………………………… | …………………………………… |
| 2. ………………………………………………………… | …………………………………… |
| 3. ………………………………………………………… | …………………………………… |
| 4. ……………………………………………………….. | …………………………………… |

c) That the injection administered were/were not for immunising or prophylactic purpose;
d) That the patients is/was suffering from………………………………………….and is/was under treatment from……………………………. to……………………………
e) That the X-Ray, laboratory tests, etc. for which an expenditure of Rs……………………………was incurred were necessary and were undertaken on my advice at…………………………………………. (name of the hospital or laboratory)
f) That I called on Dr……………………………………………………………… for specialist consultation and that the necessary approval of the……………………………………………..(name of the chief Administrative Medical Officer of the State) as required under rules, was obtained.

Signature and Designation of the
Medical Officer in charge of the
Case at the hospital