(101

FOR CHRONIC PATIENT

Chronic Certificate No.
Dt.

CCS HARYANA AGRICULTURAL UNIVERSITY
ESSENTIALITY CERTIFICATE
(To be filled in Capital Letters ____

Name of Claimant______________________ Period of Treatment From__________To__________

Designation______________________ Departmennt______________

Outdoor/Inddor No. ______________ Date__________

Basic Pay ______________(In case of pensioner last Basic Pay)

I, certify that Mr./Mrs.______________________Son/daughter/wife/mother/father of Mr./Mrs.______________________has Employed in the office of the ______________been under my treatment in the ______________Hospital/Dispensary. In my consultation and that the under mentioned medicines prescribed by mew in this connection were absolutely essential in the condition of the patient. The medicines were not stocked in the ______________(Name of Hospital/Dispensary) for the supply to the patient and do not include preparation for which cheaper substitute of equal the repute value are available/nor the preparations prescribed are primary food/toilets/tonics of disinfectants.

6. Certified that medicines have no cheaper and effective substitute.
7. Certified that the treatment given was indoor/outdoor.
8. Certified that the price claimed is reasonable.
9. Certified that the medicines are not in the nature of tonics of food or vitamins etc. The cost of which is not reimbursable in the Govt. orders issued on this subject from time to time.
10. He /She is suffering from______________(in capital letters)

Sr. No.	Name and quantity of medicines in capital letters	Outdoor ticket No. & date on which prescribed	Date on which actually purchased	Price Rs. Paise

Medical claim form

100 Copies

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Countersignature & Designation of
Supdt./SMO/Authorised
Doctor of the Hospital/College

Checked & Verified the bill

Medical Officer Pharmacist Asstt.

Countersignature

Signature and Designation
Authorized Medical Attendant/Officer

Senior Medical Officer
Campus Hospital, CCS HAU, Hisar

MEDICAL RE-IMBURSEMENT FORM

In case of Indoor Treatment

Certified that the medicines claimed in this bill are as per bed ticket (No. _____) relates to the case.

Signature & Stamp of authorized
Medical Attendant/Officer

Certified that:

1. The medicines have actually been purchased by me during the course of treatment.
2. I am living in the House No. _____.
3. In case of wife/children:
   That the patient Mr/Mrs. _____ is my _____ and he/she is wholly dependent upon me and is residing with me and he/she is unmarried and unemployed (in case of sons/daughters).
4. For parents only:
   His/her total monthly income does not exceed Rs. 3500/- p.m. and my mother/father is/are residing with me.
5. In case spouse is working:
   d) Certified that my wife/husband is not getting any ..... medical allowance from any source.
   e) Certified that my wife/husband is employed and is not getting any medical reimbursement from any other source. An affidavit to this effect has been furnished.
   f) Certified that I am not adhoc employee and am working on regular basis.

Signature of Claimant

(Name and designation in capital letters)

Place _____

Date _____

CHAUDHARY CHARAN SINGH HARYANA AGRICULTURAL UNIVERSITY

CCS HARYANA AGRICULTURE UNIVERSITY, HISAR

Form for Reimbursement of Medical Charges

Name & Designation of the employee claiming reimbursement with department: _____

Sr. No.	Name & relationship of the patient with the university employee (along with passport size photograph)	Disease as diagnosed by the authorized medical officer	Name of medicines on account of which the expenditure was incurred	Amount of the bill (Rs)	Place of posting	Reasons for incurring expenditure at place other tan the place of duty posting	Period of treatment	Remarks
1	2	3	4	5	6	7	8	9
	i) Name of patient ii) Relationship with the university employee iii) Photograph of the patient Above particulars attested HOD Countersigned C.M.O.							

1	2	3	4	5	6	7	8	9

Form AU 5/12

Certified that:

(i) Parents as mentioned above are wholly dependent upon me and have no other source of income except that the monthly income of my parents does not exceed Rs. _____

(ii) They reside with me at the place of my duty.

(iii) The medicines purchased have been fully used.

1. Registration No. of the Medical Practitioner is
2. In case Spouse is working
   a) Certified that my wife/husband is not getting any fixed medical allowance from any source.
   b) Certified that my wife/husband is employed and is not getting medical reimbursement from any other source. An affidavit to this effect has already been furnished.

Signature of the employee
(with date)

Counter signature_____
Designation
(With Seal)

Certified that the medicines as detailed herein are not available in the Campus Dispensary and are admissible under the Punjab Govt. Medical Attendance Rules, 1940.

_____
Medical Officer
CCS Haryana Agricultural University.

Note:

1. Prescription should indicate:
   (a) No. of the Regd. Medical Practitioner.
   (b) Name of the Medicine in legible handwriting.
   (c) Quantity of the medicine to be purchased from the market.
2. Cash Memo/Vouchers should be duly verified and attested by the employee concerned in token of payment, having been made.
3. Name of the medicine to be given in capital letters on the reverse side of the voucher.
4. Sanction of the competent authority to be enclosed.