INDIAN INSTITUTE OF SCIENCE

BANGALORE - 560012

Form of application for claiming refund of medical expenses incurred in connection with medical attendance and/or treatment of members of Staff of the institute.

1. Name and designation of member of staff
(in block letters)

2. Office in which employed — Indian Institute of Science, Bangalore

3. Pay of the member of Staff
(Pay, Personal Pay, Special pay)

4. a) Place of Duty (Dept./Sec./Lab) — ELECTRICAL ENGINEERING DEPT.
b) If working in the scheme, name of the scheme may be indicated.

5. Actual residential address

6. Name of the patient and his/her relationship to the member of staff. Whether employed and if so indicate the designation and the name of the Office in which employed.

N.B. i) In the case of children, state age also
ii) In the case of parents, please certify that they are wholly dependent on you and their total income per month is not more than Rs. 350,

7. Place at which the patient fell ill

8. Nature of illness and duration

9. Details of the amount claimed :
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 consultations and the fee paid for each consultation.

c. The number and dates of injection and the fee paid for each injection.

d. Whether consultation and/or injections were had at the consulting room of the Medical Officer, at the hospital or at the residence of the patient.

ii) Charges for pathological, bacteriological radiological and other similar tests undertaken during diagnosis indicating :

a) The name of the hospital or laboratory where the tests were undertaken, and

b) Whether the tests were undertaken on the advice of the authorised medical attendant, if so, a certificate to that effect should be attached,

c) The names of the tests undertaken

d) The size and no, of the x - ray films taken

iii) Cost of medicines, purchased from the market

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

10) Total amount claimed

11) List of enclosures

(DECLARATION TO BE SIGNED BY THE MEMBER OF STAFF)

I hereby declare that the statements in this application are true to the best of my knowledge and belief,

Signature of the members of staff

Designation :

Dept,/Section :

(INDIAN INSTITUTE OF SCIENCE)
BANGALORE - 560012

Date :

INDIAN INSTITUTE OF SCIENCE
BANGALORE - 560012

CERTIFICATE granted to Mr./Mrs./Ms.....
related as.....to Mr./Ms.....
Employed in the Dept/Section/Unit/Lab.....Indian Institute of Science, Bangalore - 560012.

CERTIFICATE 'B'

(To be completed in the cased of patients who are admitted to hospitals for treatment)

PART 'A'

(To be signed by the Medical Officer in charge of the.....case of the Hospital)

1. Dr.....Here by certify

2. That the patient has been under treatment as.....And that the under mentioned medicines prescribed by me in this connection were essential for the recovery/ prevention of serious deterioration in the condition of the patient the medicines are not stored in the .....(Name of the Hospital) for supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available nor preparation which are primarily foods, toilets or disinfectants.

Name (s) of the Medicines	Prise Rs. Ps.
a.	
b.	
c.	
d.	
e.	
f.	

3. That the injections administered were/are not for immunising or prophylactic purpose.

4. That the patient was suffering from.....
And is/was under my treatment from.....to.....

5. That the X ray , Laboratory tests etc. for which an expenditure of Rs..... is/was incurred were necessary and were undertaken on advice at..... .....(Name of the Hospital/Laboratory)

6. That I called on Dr.....for special consultation.

Signature and Designation of the Medical Officer in charge of the case at the Hospital

PART 'B'

I Certify that the patient has been under treatment at..... Hospital and 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

COUNTER SIGNED

Medical Superintendent,.....Hospital.

I Certify that the patient has been under my treatment at .....Hospital and that the facilities provided were the minimum which were the essential for the patient's treatment.

Place :
Date :

Signature
(with name and Designation)

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