Institute of Home Economics
(University of Delhi)
F-4, Hauz Khas Enclave, Hauz Khas,
New Delhi, Delhi - 110016

FORM OF THE APPLICATION FOR CLAIMING REFUND OF MEDICAL EXPENSES INCURRED IN CONNECTION WITH MEDICAL ATTENDANCE AND / OR TREATMENT OF COLLEGE EMPLOYEE AND THEIR FAMILIES

N.B:- Separate form should be used for each patient.

1.	Name and Designation of the employee (in Block Letters)	
(i)	Whether married or unmarried	
(ii)	If married the place where wife/husband of the employee is employed (where applicable)	
2.	Pay of the employee, and other emoluments which should be shown separately	
3.	Residential Address	
4.	Name of the patient and his / her, Relationship to the employee N.B. In case of children state age also	
5.	Place at which the patient fell ill	
6.	Whether member of W.U.S. Health center or Not	
7.	Details of the amount claimed: MEDICAL ATTENDANCE	
(i)	Fees for consultation, including	
(a)	The name, qualification and designation of the medical officer consulted and the hospital or dispensary to which attached	
(b)	The number and dates of consultations and the fees paid for each consultation.	
(c)	The number and dates of injections and the fee paid for each injection	
(d)	Whether consultations and / or injection were had at the hospital at the consulting room of the medical officer or at the medical officer orate the residence of the patient.	

(ii)	Charges for pathological, bacteriological, radiological, or other similar tests undertaken during diagnosis indicating	
(a)	The name of the hospital or laboratory where undertaken and	
(b)	Whether the tests were undertaken on the advice of the authorized medical attendant. If so, a certificate to that effect should be attached.	
(iii)	Cost of medicines, purchased from the market (list of medicines, cash memos, and the essential certificates should be attached.)	
8.	Total amount claimed	
9.	List of enclosures :- 1. Copy of Doctor's prescription 2. Cash Memo	

DECLARATION TO BE SIGNED BY THE COLLEGE EMPLOYEE

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

2. Bill is pre receipted.

Date …… Signature of the employee

(FOR OFFICE USE ONLY)

Pay to ……...

Passed for Rs. …… (Rupees …...……

…….

……..)

Dealing Asst. S.O. (A/cs) A.O. Director