Form of Application for Claiming Refund of Medical Expenses incurred in connection with the Medical Attendance and/or treatment of Officers/Staff of the Food Corporation of India and their Families.

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

1. Name & Designation of the employed
   (IN BLOCK LETTER)

   (i) Whether married or unmarried

   (ii) if married, the place where wife/husband is employee

2. Division in which posted

3. Pay of the employee as defined in the Fundamental Rules, and any other emoluments, which should be shown separately.

   Pay Rs. Dept. allow. Rs. DA Rs. HRA Rs. CCA Total Rs.

4. Place of Duty

5. Actual residential Address

6. Name of the patient and his/her relationship to the employee (N.B. : In the case of children, father, mother, state age also)

7. Place at which patient fell ill

8. Details of the amount claimed

i) MEDICAL ATTENDANCE :-

   (a) Fees for consultation, indicating :-

   (b) The name and designation of the Medical Officer consulted and the hospital or dispensary to which attached.

   (c) The number and dates of consultation and the fee paid for each consultation.

   (d) The number and date of injections and the fee paid for each injection.

   (e) Whether consultation and or injections were had at the hospital and the consulting room of the Medical Officer or at the residence of patient.

ii) (a) Charges for pathological, bacteriological, radiological or other similar tests undertaken during diagnosis, indicating :-

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

   (c) Whether the tests were undertaken on the advice of the authorised medical attendant. If so, a certificate to that effect should be attached.

iii) Cost of medicine purchased from the market (List of the medicines, cash memos, and the essentiality certificate should be attached).

I. HOSPITAL TREATMENT

III. CONSULTATION WITH SPECIALIST

Fees paid to specialist or a Medical Officer other than the authorised medical attendant indicating.

(a) The name and designation of the Specialist in Medical Officer consulted and the hospital to which attached.

(b) Nos. and dates of consultations and the fee charged for each consultation.

(c) Whether consultation was had at the hospital at the consulting room of the specialist or Medical Officer or the residence of the patient.

(d) Whether the Specialist or Medical Officer was consulted on the advice of the authorised medical attendant.
9. Total Amount claimed

10. List of enclosures (1) (2) (3) (4)

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**DECLARATION TO BE SIGNED BY THE EMPLOYEE**

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

Signature of the Employee & Designation (Name & Section)

Date:

TO BE FILLED IN BY THE APPLICANT

Bank A/c No.

Name and Address of Bank

Name of Disease:

Duration: From...To...

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**DETAILS OF MEDICINES PURCHASED**

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Cash Memo No. &amp; Dt.</th>
<th>Name of Medicines (IN BLOCK LETTERS)</th>
<th>Qty</th>
<th>Price Rs. P.</th>
<th>Shop from which purchased</th>
<th>Remarks</th>
</tr>
</thead>
</table>

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**FOR OFFICE USE**

1. Consultation/Diet
2. Injections/Medical Advice etc.
3. Nursing & accommodation
4. Confinement, operation etc.
5. X-ray, Pathological Test etc.
6. Cost of medicines

PASSED

Rs............................(Rupees............................)

Asstt. Manager (Accounts) Asstt. General Manager (A/cs)

Debit Officer Cat. I/Officer Cat. II 15.982 Officers/Staff/Retired 5.150-"B"/5.150"C 16.982

Stamp Revenue