मोतीलाल नेहरू कॉलेज
MOTILAL NEHRU COLLEGE
(दिल्ली विश्वविद्यालय)
(DELHI UNIVERSITY)

बेनिटो जुआरेज मार्ग, नई दिल्ली-110021
BENITO JUAREZ MARG : NEW DELHI - 110021

1. Name of Employee / कर्मचारी का नाम.....

Bank Account No./ बैंक खाता संख्या..... Designation/ पद.....

B. Pay/ मूल वेतन.....Allowance/ भत्ते.....Total/ कुल.....

2. Date of Submitting the Bill/Bills/ बिल/बिल जमा करने की तिथि.....

3. Nature of Bill/ बिल की प्रकृति..... No. of Bills / बिलों की संख्या.....

बिल का विवरण

Bill No. & Date / बिल नंबर और तारीख	Name of the Patient / रोगी का नाम	Relationship / संबंध	Amount / राशि

Consultation/ परामर्श.....Medicine/ दवा.....

LabTest/ लैब टेस्ट .....

Others/अन्य.....

Total Rs./कुल रू.....

Signature of Employee /
कर्मचारी का हस्ताक्षर

Bill/s entered in the Medical Register at Page No./ पृष्ठ संख्या पर मेडिकल रजिस्टर में दर्ज किए गए बिल.....

Permissible expenditure of total Bills Rs./ कुल बिलों का अनुमेय व्यय रू.....

Debatable to Medical Reimbursement A/c/ डेबिट योग्य चिकित्सा प्रतिपूर्ति ए/सी. के लिए

Asstt./ सहायक	Sr. Asstt./ वरिष्ठ सहायक	S.O. (Admn.)/ अनुभाग अधिकारी (प्रशासन)	S.O. (Acctts.)/ अनुभाग अधिकारी (लेखा)

A.O. Acctts./ प्रशासनिक अधिकारी लेखा	A.O. (Admin.) प्रशासनिक अधिकारी (प्रशासन)	Bursar/ बरसर	Principal/ प्राचार्य

Motilal Nehru College
(UNIVERSITY OF DELHI)

APPLICATION FORM FOR CLAIMING REFUND OF MEDICAL EXPENSES INCURRED IN CONNECTION WITH MEDICAL ATTENDANCE AND/OR TREATMENT OF UNIVERSITY EMPLOYEES AND THEIR FAMILIES

N.B. SEPARATE FORM SHOULD BE USED FOR EACH PATIENT

1 Name and designation of the employee: (in Block Letters)._____

(i) Wheter Married or Unmarried:_____

(ii) If married, the place where wife/husband of the employee is employed (where applicable)._____
(in case employed, Joint Declaration duly countersigned by the wife employer/husband of the child may be furnished at the time of first bill in each financial year).

2. Where Employed: MOTILAL NEHRU COLLEGE, BINTO JUARAZ MARG, NEW DELHI-110021

3. Pay of the University/College employee, and any other emoluments, which should be shown separately: B.P._____

Other Allowances_____

Total_____

4. Place of Duty: MOTILAL NEHRU COLLEGE LAB/LIBRARY/OFFICE

5. Actual Residential Address:_____

6. Name of the Patient and his / her relationship to the University/College employee

Note: in the case of children state age also.

7. Place at which the patient fell'ill:_____

8. Whether member of W.U.S. Health Centre or Not:_____

9. ***Details of the amount claimed:***

(i)

MEDICAL ATTENDANCE/HOSPITAL TREATMENT

(a) The name qualification and designation of the medical officer consumed and the hospital or dispensary to which attached.:_____

(b) The number and date, of consultation and the fee paid for each consultaion.:_____

(C) The number and dates of injections and the fee paid for each injection.:_____

(d) Whether consultations and / or injections were had at the hospital in the consulting room of the medical officer or at the residence of the patient_____

(ii) ***Charge for pathological, Bacteriological, Radiological or other similar tests undertaken during diagnosis indicating:***

(a) The name of the hospital or laboratory where tests were undertaken_____

(b) and 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 medicines, purchased from the market._____

(List or medicines, Cash memos and the Essential certificates should be attached.)

10. Total amount claimed : Rs. _____

11. List of enclosures :_____

_____

DECLARATION TO BE SIGNED BY THE UNIVERSITY/COLLEGE EMPLOYEE

I hereby declare that statement in this application are true to the best of my knowledge and belief that the person for whom medical expenses were incurred is residing with me and wholly dependent upon me and his/her income is less than Rs. 9000/-p.m.+ D.R from all sources.

(PRE-RECEIPTED)

Dated .....

Signature of College Employee

(1) 5% empties of the used medicines as wrappers, vials, bottles are enclosed for verification and destruction.

(2) All the empties, as wrappers, vials, bottles are enclosed for verification and destruction as the amount has exceeded Rs. 1000/- during the financial year.

(3) Entry of this Medical Bill is made at page No. .....Sr. No. .....of Medical Bill Register.

Signature of the controlling authority with Office Seal