

# CENTRAL UNIVERSITY OF HARYANA

(Established vide Act No. 25 (2009) of Parliament)

VILLAGES (JANT-PALI), MAHENDERGARH, HARYANA

Temporary Camp Office: Govt. B.Ed. College Building, Narnaul (Distt. Mahendergarh) Haryana

Temporary Camp / Transit Office: 3113, DLF Phase III, Opp. H. No. T-25/8, Gurgaon – 122 010

## Form of the application 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) Whether married or unmarried :
  - (ii) If married the place where wife/  
Husband of the employee is employed  
(Where applicable)  
  
(In case employed a 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. 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 the case of children state age also.
5. Place at which the patient fell ill:
6. 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 dated of consultations  
and the fee paid for each consultation. :
    - (c) the number and dated of injections and  
the fee paid for each injection. :
    - (d) whether consultations and/or injections  
were had at the hospital at the consulting  
room of the medical officer or at the  
residence of the patient. :
  - ii) Costs of medicines, purchase from the market :

(list of medicines, cash memos, and the essential certificates should be attached)

7 Total amount claimed :

8 List of enclosures :-

1. ....
2. ....
3. ....
4. ....
5. ....

**Declaration to be signed by the University 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) I also certify that there is no co-operative store/medical store run by government or Super Bazaar within the radius or 3 k.m. from my residence.

BILL IS PRE-RECEIPTED.

(Signature of employees)

Date.....

Certified that necessary entries have been made in record. Entered in the medical Register on page No. \_\_\_\_\_ Sr. No. \_\_\_\_\_

**Dealing Assistant**

**Finance Officer**

(To be filled in by the Accounts Section)

Bill passed for Rs.....

Paid vide cheque No. ....dated.....

**Assistant Registrar**

**OSD(IA)**

**Finance Officer**

**Registrar**