INDIAN INSTITUTE OF ADVANCED STUDY
RASHTRAPATI NIVAS, SHIMLA-171 005

MEDICAL CHARGES REIMBURSEMENT FORM

1. Name and Designation :.....
2. Office in which Employed :.....
3. Basic Pay :.....
4. Name of Patient & relation with the Claimant :……..
5. Period of Illness : .....
6. PARTICULARS OF TREATMENT:

Item Names	Charges	Details of Cash-Memos etc.
(i) Medicines (Name)		

(ii) Laboratory Tests/Ambulance/Consultancy/Indoor Room/Others (Specify)		

7. Total Claim Rs ……..

8. *Less*- Advance Drawn *vide* T/V

No .....……Dt ……Rs ... ……..

9. Net Amount Payable Rs…….

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 on me.

Date …… *(Signature of the Claimant)*

VERIFICATION CERTIFICATE

I, Dr. ……hereby certify that…… suffering from……and is/was under my treatment from ……to……and that the above mentioned Medicines/tests were prescribed by me in this connection. The claim is verified for Rs……

Date .....

(Signature of Medical Officer)
Designation & Seal

(COUNTERSIGNED BY RESIDENT MEDICAL OFFICER, IIAS)

Passed for Rs. .....……(Rupees.....……..) and

included in Bill No.....……..Dated .....….

Dealing Assistant **Account Officer** **Secretary** **Director**