
	ICAR– Central Institute for Research on Goats, Makhdoom, Mathura		Doc. No.: CIRG/IS/26
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**APPLICATION FORM FOR REIMBURSEMENT OF IPD MEDICAL EXPENDITURE**

1. Name of the Government Servant : .....
2. Designation : .....
3. Division/ Section/ Unit : .....
4. Pay Level/ Grade Pay : .....
5. i. Whether married or unmarried. : .....
- ii. If married the place where wife/  
husband is employed : .....
6. Name of patient & his/her :  
relationship with the Govt. servant : .....
7. **DETAILS OF THE AMOUNT CLAIMED:**
  - a. Name of the Hospital where the :  
patient was admitted. : .....
  - b. The Date of admission and the Date :  
of discharge from the Hospital. : .....
  - c. Type of Room/ Ward in which the :  
Patient was admitted. : .....
  - d. Amount paid for the Room/ Ward :  
in which the Patient was admitted. : .....
  - e. Amount paid for the pathological :  
bacteriological, radiological or other  
similar tests undertaken. : .....
  - f. Amount paid for the Medicines. : .....
  - g. Amount paid for surgery, if any. : .....
  - h. Amount paid for nursing and other :  
charges during stay in the Hospital. : .....
  - i. Total Amount claimed : .....
8. List of enclosures : .....

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### DECLARATION

**I hereby declare that:**

- 1. The statements made in the Application are true to the best of my knowledge and belief.**
- 2. The reimbursement is being claimed for the amount which has been actually incurred by me.**
- 3. The person for whom medical expenses were incurred is wholly dependent upon me.**
- 4. All the bills and vouchers have been countersigned by the Medical Authority.**


**Place:**

**Dated:**

**Signature of the Employee**

**Forwarded by concerned Head/ in-charge**

**(Name, Designation & Dated Signature)**

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**ESSENTIAL CERTIFICATE ‘B’**

**(To be completed in the case of Patients who are admitted in Hospital for Treatment)**

Certificate granted to Mr./ Mrs./ Miss/ Dr./ .....  
Wife/ son/ Daughter of Mr./ Mrs./ Dr.....  
Employed in the .....


**PART – A**

I, Dr..... hereby certify that:

- a. That the Patient was admitted to .....Hospital on the advice of ..... (name of the Medical Officer)/ on my advice.
- b. That the patient has been under treatment at ..... Hospital and that the under mentioned medicines prescribed by me in this connection were essential for the recovery / prevention of serious deterioration in the condition of the patient. The medicines are not stocked in the ..... Hospital for supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available nor preparations which are primarily foods, toilets or disinfectants:

Sl. No.	Name of the Medicines/ Cash Memo No. with Date	Total Amount (in Rs.)
<b>TOTAL AMOUNT FOR MEDICINES</b>		

- c. That the injections administered were/ were not for immunizing or prophylactic purposes.
- d. That the patient is /was suffering from ..... (in block letters) and is / was under my treatment from ..... to .....

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- e. That the pathological, bacteriological, radiological or other similar tests for which an expenditure for Rs. .... was incurred were necessary and were undertaken on my advice at ..... (Name of the hospital / Laboratory).
- f. That I called on Dr. .... for specialist consultation and that the necessary approval of the ..... as required under the rules was obtained.

**Signature and Designation of  
the Medical Officer in charge  
of the case at the Hospital**

### PART-B

I certify that the patient has been under treatment at the ..... Hospital and that the service of the special nurses for which an expenditure of Rs..... was incurred, vide bills and receipts attached, were essential for the recovery/ prevention of serious deterioration in the condition of the patient.

**Signature and Designation of  
the Medical Officer in charge  
of the case at the Hospital**

### COUNTERSIGNED

I certify that the patient has been under treatment at the ..... Hospital and that the facilities provided were the minimum which were essential for the patients treatment.

Place:

**Seal and Signature of the  
Medical Superintendent**

Dated:

..... Hospital

*(Note: Certificates not applicable should be struck off. Certificate is compulsory and must be filled in by Medical Officer in all cases)*