MEDICAL REIMBURSEMENT FORM

Employee Details		
Emp Type:	**Emp Id**:	**Name**:
Email:	**Mobile Number**:	**Employee Designation**:

Address Details		
Residential Address:		
House No:	**Street No**:	**State**:
District:	**Villages/Cities/Towns**:	
Office Address:		
House No:	**Street No**:	**State**:
District:	**Villages/Cities/Towns**:	

Employee Pay Details		
Pay Source:	**PRC**:	**State**:

POSTING DETAILS		
HOD Name:	**DDO Code**:	**District**:

Treatment Details		
Treatments For:	**Patient Name**:	**Patient Gender**:
Patient Date Of Birth:	**Age**:	**Relation With Employee**:
Hospital Name:	**Hospital State**:	**Hospital Distric**:
Date Of Admission:	**Date Of Discharge**:	**Total Amount Claimed**:
Is Hypertensive:	**Is Diabetic**:	

Declaration

I hereby declare that the statement in the application is true to the best of my knowledge and belief and that the person from whom medical expenses were incurred is a member of my family as defined under the Government servant Medical attendance rules 1972 and wholly dependent upon me.

Signature of DDO

with Office Seal

Signature of Employee/Pensioner