Shaheed Rajguru College of Applied Sciences for Women
शहीद राजगुरु कॉलेज ऑफ एप्लाइड साइंसेज फॉर वुमेन
University of Delhi
दिल्ली विश्वविद्यालय
Vasundhara Enclave, Delhi – 110096
वसुंधरा एन्क्लेव, दिल्ली - 110096

MEDICAL FORM

Certificate – A

Certificate granted to _____ S/o, W/o, D/o _____ employed in the Shaheed Rajguru College of Applied Sciences for Women, Vasundhara Enclave, Delhi-110096.

1. Dr. _____ hereby certify –

(i) That I charged and received Rs. _____ /- for _____ one consultation on _____ date/s to be given at my consulting room/at the residence of patient.

(ii) That I charged and received Rs. _____ /- for administering _____ intravenous/intra muscular injections or subcutaneous. on _____ at the my consulting room/residence of the patient

(iii) That injections administered were/were not for immunizing or prophylactic purposes.

(iv) That the patient has been under treatment at _____ hospital/my consulting room 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 _____ (Name of Hospital) for supply to private patients and do not include proprietary preparations for which cheaper substances of causal therapeutic value are available not preparations which are primarily foods, toilets or disinfectants.

S.No.	Name of medicines (in block letters)	Price
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
	Grand Total	

(v) That the patient is /was suffering from _____ and is/was under my treatment from _____

(vi) That the patient is /was not given pre-natal or post natal treatment

(vii) That the x-ray, Laboratory, etc for which an expenditure of Rs. _____was incurred were necessary and were under taken on my advice at _____ (Name of hospital or Laboratory)

(viii) That I referred that patient of Dr. _____ for specialist conciliation and that the necessary approval of the _____ (Name of the Chief Administrative Medical officer of the state) as required under the rules was obtained.

(ix) That the patient did not require/ required hospitalization

Signature and designation of the
Medical officer and Hospital/ Dispensary
In which attached with seal

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Form of the Application for claiming refund of medical expenses incurred in connection with Medical Attendance and \or treatment of college employee 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)	
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 case of children state age also	
5	Place at which the patient feel ill	
6	Whether member of W.U.S. Health center or Not	
7	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 dates of consultations and the fees paid for each consultation.	
©	The number and dates of injections and the fee paid for each injection	
(d)	Whether consultations and / or injection were had at the hospital at the consulting room of the medical officer or at the medical officer orate the residence of the patient.	
(II)	Charges for pathological, bacteriological, radiological, or other similar tests undertaken during diagnosis indicating.	
(a)	The name of the hospital or laboratory where undertaken and	
(b)	Whether the tests were undertaken on the advice of the authorized medical attendant. If so, a certificate to that effect should be attached.	
(III)	Cost of medicines, purchased from the market (list of medicines, cash memos, and the essential certificates should be attached.)	
8	Total amount claimed	
9	List of enclosures :- 1. Copy of Doctor's prescription 2. Cash Memo	

Declaration to be signed by the College 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. Bill is pre receipted

Date

Signature of the employee

Dealing Assistant

Administrative Officer (offg)

Accounts Officer (offg)

Bursar

Principal

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MEDICAL FORM

Certificate – B

(To be completed in case of patients who are admitted to hospital for treatment)

Certificate granted to Mrs. / Mr. / Ms. _____ wife / son/ daughter of Mrs. / Mr. _____ employed in the _____

Part – A

(To be signed by the medical officer in charge of the _____ in case of hospital)

I, Dr. _____ hereby certify –

(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 _____ 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 _____ (name of the hospital) for supply to private patients and do not include proprietary preparations for which cheaper substances for equal therapeutic value are available nor preparations which are primarily, foods, toilets or disinfectants.

	Name of the medicines	Price
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

(c) That the injections administered were/ were not for immunizing of prophylactic purposes.

(d) That the patient is / was suffering from _____ and is / was under treatment from _____ to _____

(e) that the x – ray, laboratory tests etc. for which an expenditure of Rs. _____ was incurred were necessary and were undertaken on my advice at _____ (name of hospital)

(f) that I called on Dr. _____ for specialist consultation and that the necessary approval of the _____ (name of the Chief Administrative Medical Officer of the State) as required under the rules, was obtained.

Signature and designation of the
Medical Officer in charge of the
case at the hospital

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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 of the Medical Officer
in charge of the case at the hospital

Countersigned
Medical Superintendent
_____
Hospital

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 patient's treatment.

Medical Superintendent
_____
Hospital

Place –

Note – Certificates not applicable should be struck off. Certificate (d) is compulsory and must be filled in by the medical Officer in all cases.