राजीव गांधी राष्ट्रीय युवा विकास संस्थान
Rajiv Gandhi National Institute of Youth Development
युवा कार्यक्रम विभाग **/ Department of Youth Affairs**
युवा कार्यक्रम और खेल मंत्रालय, भारत सरकार
Ministry of Youth Affairs & Sports, Government of India
श्रीपेरुम्बुदूर **Sriperumbudur – 602105 /** तमिल नाडु **/Tamil Nadu**

FORM OF APPLICATION FOR CLAIMING REFUND OF MEDICAL EXPENSES INCURRED IN CONNECTION WITH MEDICAL ATTENDANCE AND / OR TREATMENT OF GOVERNMENT SERVANTS AND THEIR FAMILIES (OUT-PATIENT)

(Separate form should be used for each patient)

1. Name and designation of Government Servant (in BLOCK letters) :
2. Office in which employed : Rajiv Gandhi National Institute of Youth Development
3. Pay of the Government servant as defined in the fundamental Rules and any other emoluments which should be shown separately :
4. Place of Duty : Sriperumbudur – 602 105
5. Actual Residential Address :
6. Name of the patient and his / her relationship to the Government Servant :
7. Place at which the patient fell ill :
8. Details of Amount Claimed
   - **(i) Fees for consultation indicating**
     - (a) The name and designation of the Medical Officer consulted and the hospital or dispensary to which attached :
     - (b) The number and dates of consultation and the fee paid for each consultation :
     - (c) The No. and dates of Injection and the fee paid for each injection :
     - (d) Whether consultations and or injections were at the hospital, at the consulting room of the medical officer or at 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 the tests were undertaken :
     - (b) Whether the tests were undertaken on the advice of the authorized medical attendant; if so, a certificate to the effect should be attached :
   - **(iii) Cost of medicines purchased from the market (List of Medicines, cash memos and the essentiality certificates should be attached)** :
9. Total Amount Claimed :
10. List of Enclosures :

DECLARATION TO BE SIGNED BY THE GOVERNMENT SERVANT

I hereby declare that the statements in this application are true to the best of my knowledge and the belief that the person or whom medical expenses were incurred is wholly dependent upon me.

Date:

Signature of the Govt. Servant and
Section / Department to which attached

Certificate granted to _____

CERTIFICATE "A"

1. Dr. _____ hereby certify

   a. That I charged and received Rs. _____ for _____ consultation(s) on _____ (dates to be given) at my consulting room / at the residence of the patient out of hospital hours.

   b. That I charged and received Rs. _____ for administering _____ _____ intravenous / intra-muscular / subcutaneous injection(s) on _____ (dates to be given) _____ at my Consulting Room / at the Residence of the patient out of hospital hours.

   c. That the injections administered were / were not for immunizing or prophylactic purposes.

   d. That the patient has been under treatment at my hospital / at 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 Dispensary for supply to the patient and do not include proprietary preparations for which cheaper substitute, substance and equal therapeutic value are available nor preparations which are primarily food, toilets or disinfectants.

Name of the Medicines	Quantity	Price

   e. That the patient is / was suffering from _____ and is / was under my treatment from _____ to _____

   f. That the patient is / was not given prenatal treatment.

   g. 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 the Hospital or Laboratory)

   h. That I referred the patient to Dr. _____ for specialist consultation and that the necessary approval of the _____ (Name of the Chief Admn. / Medical Officer of the State) as required under rules were obtained.

   i. That the patient did not require / required hospitalization.

   j. That the case is / was not one of prolonged treatment.

Station:
Date:

Signature and Designation of the
Medical Officer and the Hospital /
Dispensary to which attached

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Certificate not applicable should be struck off.
Certificate 'e' is compulsory and must be filled in by Medical Officer in all cases.