

**RETIRED EMPLOYEE**

**FILM & TELEVISION INSTITUTE OF INDIA**

**Approval of Ministry of Information and Board casting letter no. 12011/5/2019 VOL.I  
IDO(FTI) dated 23.04.2020.**

**Form of Application for claiming refund of Medical expenses incurred in connection with  
medical attendance and or treatment of Retried FTII Employee's and their spouse.**

1.(a). Name of the Retired FTII Employee

(b). FTII ID No.

(c). Validity of CARD/ID

(e). Ward Entitlement -Pvt / Semi-Pvt/ General

(f) . Full Address

(g) Mobile/ Telephone No. And e-mail address. If any

2. (a) Patient Name

(b) Relationship with card / ID Holder

3. Name & address of the hospital/ diagnostic centre/  
Imaging centre where treatment is taken or tests done

4. Whether the hospital /diagnostic/imaging center is  
Empanelled under CGHS

5. Total amount claimed

(a) OPD Treatment

(b) Indoor Treatment

(c) Tests/Investigation

(d) Treatment period.

6. Name of the Bank ..... SB A/c No.....  
Branch MICR Code.....IFSC Code.....

7. Documents to be attached.

(a) Photo copy of the ID Card of the principal card holder along with the patients card

(b) copy of permission letter, if any

(c) Copy of the discharge summary

(Original bills/cash memo / vouchers etc. For the reimbursement amount claimed.

Signature of the Retired Employee

## चिकित्सा परिचारक

(iii) बाजार से खरीदी गई दवाओं का मूल्य  
(iii) Cost of medicines purchased from the market,

( List of medicines, memos and Essentiality Certifications should be attached)

- (9) (क) दावे की कुल राशि  
(a) Total amount claimed

- (b) Less amount of advance taken on

- (ग) दावे की निवल राशि  
(c) Net amount claimed

10. अनुलग्नको की सूची -  
List of enclosures

- (i) औषध पत्र -  
Prescription -
- (ii) बा. रु. वि. पर्ची -  
OPD Slips -
- (iii) प्रमाण पत्र -  
Certificate -
- (iv) बिल  
Cash Memo (s)

[illegible]

घोषणा जिस पर सरकारी कर्मचारी द्वारा हस्ताक्षर किए जाते हैं  
DECLARATION TO BE SIGNED BY THE GOVT. SERVANT

मैं एतद् द्वारा घोषित करता / करती हूँ कि इस आवेदन में दिए गए विवरण मेरी जानकारी और विश्वास के आधार पर सत्य हैं तथा जिस व्यक्ति के लिए चिकित्सा व्यय किया गया है वह पूर्णतः मुझपर अभिहित है।

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

प्रमाणित किया जाता है कि मेरे निवासस्थान से दो कि. मी. की दूरी में सरकारी सस्ते दामों वाली दुकान, सरकारी उपभोक्ता स्टोर, केन्द्र अथवा राज्य सरकारी अथवा स्थानिक निकाय, अथवा सहकारी सोसायटी एक्ट के अन्तर्गत अन्य किसी संगठन द्वारा संचालित दवाई के भण्डार नहीं है।

Certified that there is no Govt. Fair Price Shop / Co-operative Consumers' Stores / Drug Depots run by the Central or State Govt. or Local Bodies or any other organisation under the Co-Operative Societies Act, within two kilometers radius from my residence.

दिनांक :

Date : \_\_\_\_\_

कर्मचारी के हस्ताक्षर

Signature of the Employee

प्राप्तिपूर्व रसीद  
PRE RECEIPT

दावे की राशि रु.

Amount Claimed Rs. \_\_\_\_\_

रु. \_\_\_\_\_ रुपये

की राशि प्राप्त हुई

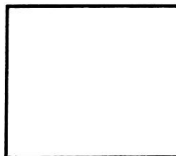
Received sum of Rs. \_\_\_\_\_

नामंजूर राशि रु.

(Less) Amount disallowed Rs. \_\_\_\_\_

Rupess \_\_\_\_\_

हस्ताक्षर / Signature



निवल रु.

Net Amount Rs. \_\_\_\_\_

नाम / Name

पदनाम / Designation

रु. ५००/- तथा इससे अधिक राशि के लिए राजस्व टिकट लगाईए।

Please affix Revenue Stamp for Rs. 500/- and above.

बैंक का नाम / Name of Bank \_\_\_\_\_

खाता नं. / Account No. \_\_\_\_\_

रु. \_\_\_\_\_ भुगतान के लिए दावा मंजूर किया गया

Claim Passed for payment for Rs. \_\_\_\_\_

कार्यवाही सहायक/D.A.

लेखा अधिकारी

ACCOUNTS OFFICER