RETIRED EMPLOYEE

# FILM & TELEVISION INSTITUTE OF INDIA

**Approval of Ministry of Information and Board casting letter no. 12011/5/2019 V01.I IDO(FTI) dated 23.04.2020.**

**Form of Application for claiming refund of Medical expenses incurred in coneection 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 hosptial/ diagnostic centre/ Imaging centre where treatment is taken or lests done

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

5. Total amount claimed
(a) OPD Treatment

(b) Indoor Treatment

(c) Tests/Ivestigation

(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 Cardof 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

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चिकित्सा परिचारक
MEDICAL ATTENDANCE

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

(दवाइयों को सूची, बिल और आवश्यक प्रमाणपत्र संलग्न किए जाए ।)
( List of medicines, memos and Essentiality Certifications should be attached)

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

(ख) अग्रिम राशि
(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)

| | संख्या एवं दिनांक<br>No. and date | राशि<br>Amount | दुकान का नाम<br>Name of the Shop |
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RETIRED EMPLOYEE

## घोषणा जिस पर सरकारी कर्मचारी द्वारा हस्ताक्षर किए जोते है
## DECLARATION TO BE SIGNED BY THE GOVT. SERVANT

मै एतद् द्वारा घोषित करता / करती हूं कि इस आवेदन में दिए गए विवरण मेरी जानकारी और विश्वास के आधार पर सत्य है तथा जिस व्यक्ति के लिए चिकित्सा व्यय किया गया है वह पूर्णत: मुझपर अश्रित 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 संचलित 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 otter oragnisation under the Co-Oprative 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.

बँक 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