ESSENTIALITY CERTIFICATE

CERTIFICATE 'A'

Certificate granted to Mrs./Mr./Miss ……..……wife/son/daughter of Mr. ……..employed in the……PCDA (SWC) Jaipur…

I , Dr. …… hereby certify :-

(a) that I charged and received Rs…….for……..……consultations on …….. (date to be given) at my consulting room/at the residence of the patient.

(b) that I charged and received Rs. ……. for administering ……. intra/muscular/sub-cutaneous injections on ……..……. at my consulting room /at the residence of the patient.

(c) that the injections administered were not / were for immunising or prophylactic purposes.

(d) 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 / preventions of serious deterioration in the condition of the patient. The medicines are not stocked in the (name of hospital) ……. for the supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available nor preparations which are primarily foods , toilets or disinfectants.

Sl.	Name of medicine	Price	Sl .	Name of medicine	Price
1					
2					
3					
4					
5					
6					

(e) that the patient is /was suffering from …… and is /was under my treatment from ……. to ……..

(f) that the patient is/was not given pre-natal or post-natal treatment.

(g) that X-ray, laboratory test,etc. for which an expenditure of Rs…….. was incurred was necessary and were undertaken on my advice at…….

(h) that I referred the patient to Dr……. for specialist consultation and that the necessary approval of the ……. (name of the Chief Administrative Medical Officer) as required under the rules was obtained.

(i) that the patient did not require / required hospitalization.

Dated …….

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

COVERED UNDER CSMA RULE Med-97

Form of application for claiming refund of medical expense incurred in connection with Medical attendance and/or treatment of Central Government servants and their families

1. Name and designation of the government servant(in Block letters) : …….

(Wife not employed any where) **A/C No.** ……

2. Office in which employed : ***Pr. C DA (SWC) Jaipur***

3. Pay of the Government servant as defined in the Fundamental Rules and Other emoluments, which should be shown separately. ***Basic pay Rs.***

4. Place of duty : ..... *Jaipur……..*

5. Actual residential address. :. ……..

6. Name of the patient and his/her relationship to the Government servant : .....

N.B. – In the case of children state age also. ……

7. Place at which the patient fell ill. : ……..

8. Details of the amount claimed –

I MEDICAL ATTENDANCE –

(i) Fee for consultation indicating –

(a) the name and designation of the medical officer consulted Dr………..

and the hospital or dispensary to which attached

(b) the number and date of consultation and the fee paid for each consultation :

© the number and dates of injections and the fee paid for each injection. :

(d) whether consultation and/or injections and were held at the hospital, at the consulting room of the medical officer or at the residence of the patient. :

(ii) Charge for pathological, bacteriological , radiological or other similar tests undertaken during diagnosis indicating-

(iii.) Costs of medicine purchased from the market. :

9.Total amount claimed . *: Rs*

10 Less advance taken as : ……. **11.Net amount claimed** : Rs.

12.List of Enclosures : ***Prescription Slip, cash memo , list of medicine, & EC.***

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 belief and that the person for whom medical expenses were incurred is wholly dependent upon me.

Dated ……. Signature of the Govt. servant and office to which attached.

Pr. C DA(SWC) JAIPUR

Name of Bank : State Bank Of India . Cantt. Branch , Jaipur

S.B. Account No.

LIST OF MEDICINE

Sl. No.	Name of Medicine	Price
1	AZINTRA -250MG	81
2	LARYNEX	15
3	MERICOF	44.50
4	NIMPRO	9.57
5		
6	TOTAL	150.07

(D. K. Gupta)
Sr. Auditor
A/C No. 8329917
Pr. C.D.A. (SWC) JAIPUR

LIST OF MEDICINE

Sl. No.	Name of Medicine	Price
1	AZINTRA -250MG	81
2	LARYNEX	15
3	MERICOF	44.50
4	NIMPRO	9.57
5		
	TOTAL	150.07

(D. K. Gupta)
Sr. Auditor
A/C No. 8329917
Pr. C.D.A. (SWC) JAIPUR

CERTIFICATE "B"

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

Certificate granted to Mrs. /Mr./Miss. ……..

Wife/son/daughter of Mr. ……

Employed in the ……..

PART "A"

I Dr. …… herby certify:-

(a) that the patient was admitted to hospital on the advice of ……..

……. (Name of medical officer)/ On my advice.

(b) that the patient has been under treatment at ……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 preparation for which cheaper substances of equal therapeutic value are available nor preparations which are primarily foods , toilets or disinfectants.

Name of Medicines	**Price**	**Name of medicines**	**Price**

(c) that the injections administered were not / were for immunizing or prophylactic purposes.

(d) that the patient is /was suffering from …… and is /was under my treatment from ……..…… to ……..

(e) that X-ray, laboratory test, etc. for which an expenditure of Rs…….. was incurred ware necessary and were undertaken on my advice at…….. …… (Name of hospital or laboratory).

(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

PART "B"

I certify that patient has been under treatment at the ……. Hospital and that the service of 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.

Place: ……

Medical Superintendent
…….. Hospital

COVERED UNDER CSMA RULE Med-97

Form of application for claiming refund of medical expense incurred in connection with Medical attendance and/or treatment of Central Government servants and their families

1. Name and designation of the government servant(in Block letters) : ***D. K Gupta Sr. Auditor***

(Wife not employed any where) **A/C No.** *8329917*

2. Office in which employed : ***House Keeping Section Pr. C DA (SWC) Jaipur***

3. Pay of the Government servant as defined in the Fundamental Rules and Other emoluments, which should be shown separately. ***Basic pay Rs. 15150/- PM*** Grad Pay 4200/-

4. Place of duty : …….. ***Jaipur***

5. Actual residential address. : ***73/31 Param Hans Marg Mansarovar Jaipur.***

6. Name of the patient and his/her relationship to the Government servant : Dinesh Kumar (Self)

N.B. – In the case of children state age also.

7. Place at which the patient fell ill. : …….. ***Jaipur***

8. Details of the amount claimed –

I MEDICAL ATTENDANCE –

(i) Fee for consultation indicating –

(a) the name and designation of the medical officer consulted ***Dr Mohan Tiwari S MO***

and the hospital or dispensary to which attached ***Govt. dispensary Mansarovar Jaipur***

(b) the number and date of consultation and the fee paid for each consultation :Fee nil one on 21/03/09

© the number and dates of injections and the fee paid for each injection. : ***Nil***

(d) whether consultation and/or injections and were held at the hospital, at the consulting room of the medical officer or at the residence of the patient. : ***Nil***

(ii) Charge for pathological, bacteriological , radiological or other similar tests undertaken during diagnosis indicating-

(iii.) Costs of medicine purchased from the market. : Rs. 683.71

9.Total amount claimed . ***: Rs 684/-***

10 Less advance taken as : ***Nil***

11.Net amount claimed : Rs 684/-

12.List of Enclosures : ***Prescription Slip, cash memo , list of medicine, & EC.***

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 belief and that the person for whom medical expenses were incurred is wholly dependent upon me.

Dated ……. Signature of the Govt. servant and office to which attached.

House Keeping Section Pr. C DA(SWC) JAIPUR

Name of Bank : State Bank Of India . Cantt. Branch , Jaipur

S.B. Account No. **30190807023**

FORM - 4

(Sea Rule 10) CCS (Leave rules-1992)

Medical Certificate for leave or Extension of Leave or Commutation or Leave.

Signature of the Government Servant _____

I, Dr. _____ _____ _____

After careful Personal Examination of the case hereby certify that Shri/ Smt / Kumari ……. Whose signature is given above is suffering from …….. and I consider that a period of absence from duty of ……. …….with effect from……..……. to ……..…….. is absolutely necessary for the restoration of his / her health.

Date

Authorized medical Attendant

…….. Hospital

FORM -5

Medical Certificate of Fitness to Return to duty

Signature of the Government Servant.

I, Dr. …….. Civil Surgeon/ staff Surgeon/ AMA / Registered Medical Practitioner of …… do hereby certify that we/I have carefully examined Shri /Smt /Kumari ……. whose signature is given above and find the he/She has recovered from his/her illness and is now fit to resume duties in Govt. service. We/I also certify that before arriving at that decision . We/I have examined the original medical certificate (s) and statement (s) of the case, for certified copies there of) on which Leave was granted or extended and have taken these into consideration in arriving at our /mine decision.

Authorized Medical Attendant

FORM -5

Medical Certificate of Fitness to Return to duty

Signature of the Government Servant.

I, Dr. …….. Civil Surgeon/ staff Surgeon/ AMA / Registered Medical Practitioner of …… do hereby certify that we/I have carefully examined Shri /Smt /Kumari ……. whose signature is given above and find the he/She has recovered from his/her illness and is now fit to resume duties in Govt. service. We/I also certify that before arriving at that decision . We/I have examined the original medical certificate (s) and statement (s) of the case, for certified copies there of) on which Leave was granted or extended and have taken these into consideration in arriving at our /mine decision.

Authorized Medical Attendant

MEDICAL CERTIFICATE

SIGNATURE OF GOVERNMENT SERVANT _____

I, Dr. _____ after carefully personal examination of the case hereby certify that Shri/Smt/Kumari _____ _____ whose signature is given above is suffering from _____ and I consider that a period of absence from duty of _____ (days) with effect from _____ is absolutely necessary for the restoration of his/her health.

Place :-
Date :-

Signature of Authorised Medical Attendant/
Registered Medical Practitioner.
Name _____
Regd. No._____
Address _____

MEDICAL CERTIFICATE OF FITNESS

SIGNATURE OF GOVERNMENT SERVANT _____

I _____ Civil Surgeon/ Staff. Surgeon /Authorised Medical Attendant/ Registered Medical Practitioner of _____ _____ do hereby certify that I have carefully examined Shri/Smt./Kumari _____ whose signature is given above and find that he/she has recovered from his/her illness and is now fit to resume duties in Govt. service w.e.f. _____

I/We carefully certify that before arrived at this decision I/We have examined the original medical certificate and statement of the case (or certified copies thereof) on which leave was granted or extended and have taken these into consideration in arriving at our/my decision.

Place :-
Dated :-

Signature of Civil Surgeon/Staff Surgeon / Authorised Medical Attendant/Registered Medical Practioner.

Name _____
Regt. No. _____
Address _____