SANT LONGOWAL INSTITUTE OF ENGINEERING & TECHNOLOGY
(Deemed to be University under Govt. of India, Ministry of HRD)

PROFORMA FOR MEDICAL REIMBURSEMENT

Outdoor Ticket No._____ Date_____ Basic Pay_____ Health C. No._____

1. I certify that Mr./Mrs./ _____ son/daughter/wife/mother/father of Sh._____ employed in Sant Longowal Institute of Engineering & Technology, Longowal has been under my treatment at_____ Dispensary/Hospital and that the under mentioned medicines prescribed by Medical Officer in this connection were absolutely essential for the treatment and recovery/prevention of serious deterioration in the condition of the patient. The medicines were not stocked in the _____. Dispensary/Hospital for supply to the entitled patient and do not include proprietary preparation for which cheaper substitutes of equal thereradic value are not available not the preparations are primarily foods toilets of disinfectants.
2. Certified that treatment as an indoor patient was not necessary.
3. Certified that the medicines charged have not cheaper effective substitute.
4. Certified that the medicines are not borne on the list of medical store department.
5. Certified that the medicines are not in the nature of tonic etc.
6. Certified that the medicines prescribed are not in the list of the non-reimbursable medicines/articles last reviewed vide Pb. Govt. letter No. 17014 –S. 15381 dated on HPI-170 dated 25.01.67.
7. Certified that the price claimed is reasonable.
8. She/he was suffering from_____.
9. Period of treatment was from_____ to_____.
10. Detail of medicines:

S.No.	Name of medicines (in block letters)	Quantity	Name of the chemist	Bill No. & Date	Price (Rs.)
				Total	
Total (in words)					

Amount recommended of Rs._____

Checked by _____

Signature of the authorized Medical Attendant

11. Certified that my father/mother/brother/sister is wholly dependent upon me and residing with me. She/he has not source of income of his/her own whatsoever.

12. Certified that my wife/son/daughter is wholly dependent upon me and residing with me. She/he is not in Govt, service.

13. Certified that the treatment pertains to myself.

14. Certified that the medicines were purchased and consumed during the period of treatment.

Signature of the claimant

Designation _____

Deptt/Section_____