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| G:\download.png | **SARDAR VALLABHBHAI NATIONAL INSITUTE OF TECHNOLOGY, SURAT-395007****SCHEDULE** |

I, certify that Shri/Shrimati/Kum./ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Wife/Son/Daughter of Shri. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ employ in the Sardar Vallabhbhai National Institute of Technology, Surta-7, had Been under my treatment for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ disease from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at the Hospital / Dispensary/ My consulting room that the under mentioned medicines prescribed by me in this connection were essential for the recovery / prevention of serious deterioration in the condition are ordinarily stocked / are out in stock in the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cheaper substance of equal there speutic value are available not preparations which are primary foods, tickets of disinecatants.

**NAME OF THE MEDICINES IN BLOCK LETTERS: (In case of more than 10 Bills, Please attached Separate Sheet)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Sr. No.** | **Bill No.** | **Date** | **Name of the Party** | **Bill Amount** | **Remarks** |
| **Rs.** | **Ps** |
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|  |  |  | **TOTAL RS.** |  |  |  |

1. **VISIT CERTIFICATE:**

**I Certify that the condition of the patient was such the visit was necessary at the patient home.**

1. **I Certify that my bill does not include such medicines/tablets/injections etc. which are listeness in admissible terms in the list of inadmissible medicines as per Govt. rules.**

**Signature of the Authorised**

**Medical Attendent**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of the Medical Officer**

**In-charge of the case at hospital**

1. **CERTIFICATE OF FAMILY:**

**Certified that the family member/members for whom the Medical Reimbursement was claimed in this bill is / are actually residing with me and wholly dependent upon.**

1. **CERTIFICATE OF CORRENCINESS:**

**I certify that the claim preferred by me is correct and has not been paid to me before. I have opted/ not opted the Medical Allowance.**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of the Employee / Pensioner**

**Name:**

**Employee Code No./ PPO No.:**

**Designation:**

**Deptt. / Section:**

**Countersigned for Rs. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ps. \_\_\_\_\_\_\_\_\_\_\_\_\_ Only)**

**(Rupees \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Only)**

**COLLEGE DOCTOR**