

# BIHAR AGRICULTURAL UNIVERSITY: SABOUR

## Forms of Application for Claiming Refund of Medical Expenses for BAU Employees.

1. Name & designation of the Govt. servant :  
(In Block letters).
2. Office in which employed :
3. Pay of government servant (as defined in :  
the fundamental rules and any other  
emoluments which should be shown  
separately.
4. Place of duty :
5. Actual residential address :
6. Name of the patient and his/her relationship :  
to the govt. servant (In case of children state  
age also).
7. Place at which the patient fell ill :
8. **Details of the amounts claimed**
  - I. Medical Attendance :
    - a. Name & designation of the Medical :  
Officer consulted and the hospital or  
dispensary to which attached
    - b. No. & date of consultation and fees :  
paid for each consultation
    - c. No. & dates of injections and fees :  
paid for each injection
    - d. Whether consultation and / or :  
injections were at the hospital / at the  
consulting room of the Medical  
Officer or at the residence of the  
patient.
  - II. Charges for pathological /  
bacteriological radiological or other  
similar tests undertaken during  
diagnosis indicating.
    - a. Name of the hospital or laboratory :  
where the tests undertaken
    - b. Whether the tests undertaken on the :  
advice of the AMA, if so a certificate  
to that effect should be attached
  - III. Cost of medicines purchased from the :  
market (list of medicines, cashmeos  
and essentiality certificate should be  
enclosed)

9. Total amount claimed :

10. List of enclosures :

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

**DECLARATION TO BE SIGNED BY THE GOVT. SERVANT.**

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

Dated: .....

**SIGNATURE OF THE GOVT. SERVANT  
AND OFFICE TO WHICH ATTACHED.**

**CERTIFICATE 'B'**

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

Certificate granted to Mrs. / Mr. / Miss .....  
..... wife / son / daughter of Mr. ....  
..... employed in the .....  
.....

**PART - A**

(To be signed by the Medical Officer-In-Charge of the .....  
..... case of the hospital)

I, Dr. .... hereby certify:-

(a) That the patient was admitted to hospital on the advice of / on my advice

.....

(Name of the Medical Officer)

(b) That the patient has been under treatment at .....  
..... and 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  
preparations for which are primarily foods, toilets or distant.

S.N.	Name of the Medicines	Quantity	Batch No.	Price
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

(C) That the injections administered were for / were not immunizing or prophylactic  
purposes .....

(d) That the patient is/was suffering from .....and  
is/was under treatment. From ..... to .....

(e) That the X-ray, laboratory tests, etc. for which an expenditure of Rs. ....  
was incurred were necessary and were undertaken on my advice at .....  
.....(Name of Hospital or Laboratory).

(f) That I claimed on Dr. .... for  
specialist consultation and the necessary approval of the .....  
.....

Signature and Designation of the Medical  
Officer-In-Charge of the case at the Hospital

**PART-B**

I certify that the patient has been under treatment at the .....  
.....hospital and that the  
service of the Special nurse for which an expenditure of Rs. .... was  
incurred vide bills and receipts attached, were essential for the recovery, prevention of the  
serious deterioration in the condition of the patient.

Signature and Designation of the Medical  
Officer-In-Charge of the case at the Hospital

**COUNERSIGNED**

Medical Superintendent  
.....(Hospital)

I certify that the patient has been under treatment at the .....  
hospital and the facilities provided were the minimum which were essential for the patient's  
treatment.

Place:.....

Medical Superintendent  
.....(Hospital)

Date: .....

N.B.: Certificates not applicable should be struck off. Certificate is compulsory and must be  
filled in by the Medical Officer in all cases.