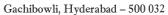
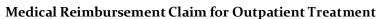
नौलाना आज़ाद नेशनल उर्दू यूनिवर्सिटी مولانا آزاد نیشتل اُر دویو نیورسی

MAULANA AZAD NATIONAL URDU UNIVERSITY





1.	. Name & Designation of the employee :				Emp.ID .No.	
2.	. Department / Branch :			Γ	David Asst No.	
3.	Pay including special pay :		:		Bank Acct. No.	
4.	Place of duty :		:		Cell No.	
5.	Actual residential address :					
6.	l)	Name of the patient and his/h Relationship to the employee	er :			
	a)	Whether married	:			
	b)	Whether Wife is employed	:			
	c)	If so, Where	:			
7.	Addı	ess/Place at which the patient	fell ill:			
8.	Deta	ils of charges paid for A.M.A./	Specialist services	indicating:		
	i)	Consultation on		amount paid ₹.		
	ii)	Injections on		amount paid ₹		
	iii)	Investigations on		amount paid ₹		
9.	Cos	t of Medicines ₹.				
10.	0. Total amount claimed ₹					
11.	List	of enclosures:				
	i)	Essentiality Certificate +A	qdated:			
	ii) Doctors prescription dated:					
	iii)		e & Address of Medical Shop	Name of the medicines and quantity	Price ₹. Ps.	
12.	De	•		n the application are true to the bical expenses were incurred is wh	•	
13.		Undertaking				
	tion		e or not as per laid	nent that is being taken by me or led-down procedure of CGHS or othe ry.		
Dat	e	:				

CERTIFICATE'A'

(To be completed in the case of patients who are not admitted to Hospital for treatment)

A.P.C. 10	Certificate granted to Mrs./Mr./Miss .				
	Son/daughter/father/mother of Mr				
	hereby certify				
(a)	That I charged and received ₹for				
. ,	consultation on(dates to be given) at my consulting room/ at the residence of the patient.				
(b)	That I charged and received ₹ for administering				
	intra-venous / intra-muscular / subcutaneous injection on				
	(dates to be given) atmy consulting room/the residence of the patient.				
(c)	That the injection administered were not/were for immunising or prophylactic purpose.				
(d)	That the patient has been under treatment atHospital/my consulting				
	room located at H.No.				
	and that the medicines prescribed by me in this connection were essential for the recovery/prevention of serious deterioration in the condition of the patient.				
(e)	The medicines are not stocked in the				
	(Name of Hospital) for supply to private patients and do not include proprietary preparations for which cheaper substance of equal therapeutic value are available nor preparations which are primarily foods, toilet or disinfectants.				
(f)	That the patient is/was suffering fromand is / was				
	under my treatment fromto				
(-)	That the mediant is / was not siven are motal treatment.				
(g)	That the patient is / was not given pre-natal treatment.				
(h)	That the X-Ray, Laboratory, Test, etc., for which an expenditure of ₹was incurred was				
	necessary and were undertaken on my advice at				
	(Name of the Hospital or Laboratory)				
(i)	That I referred the patient to Dr for				
	specialist consultation and that the necessary. Approval of the				
(*)	(Name of the Chief Administrative Officer of the State) as required under the rule was obtained				
(j)	That the patient did not require / required Hospitalisation.				
	Signature, Designation &				
	Dated: Registration No. of the Medical Officer & Hospital/Dispensary.				
	N.B.: Certificates not applicable should be struck off, Certificate (e) is compulsory and filled in by the Medical Officer in all cases.				
	Note: 1. The above certificate may be deemed to be regular receipt for the payments received by the Medical Officer, who will be required to affix a Revenue Stamp on the Essentiality Certificate itself when the payment exceeds Rs. 500.00.				
	2. The cash memos for purchase of medicines must be countersigned by the doctor				

prescribing the medicines.