

CCS HARYANA AGRICULTURAL UNIVERSITY, HISAR  
ESSENTIALITY CERTIFICATE  
(To Be Filled In Capital Letters)

Name of Claimant \_\_\_\_\_ Period of Treatment \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_  
Indoor No. \_\_\_\_\_ Date \_\_\_\_\_ Outdoor No. \_\_\_\_\_ Date \_\_\_\_\_ Designation \_\_\_\_\_  
Department \_\_\_\_\_ Pay \_\_\_\_\_ (in case of Pensioner last  
Basic Pay)

I certified that Mr./Mrs. \_\_\_\_\_ Son/daughter/wife/mother/father of  
Mr./Mrs. \_\_\_\_\_ employed in the office of \_\_\_\_\_ has been under my treatment in the  
\_\_\_\_\_ Hospital/Dispensary in my consultation and that the under mentioned medicines prescribed by me in this  
connection were absolutely essential in the condition of the patient. The medicines were not stocked in the \_\_\_\_\_ (Name of  
Hospital/Dispensary) for the supply to the patient and do not include preparation for which cheaper substitute of equal the repete value are  
available/nor the preparations prescribed are primary food/toilets/tonics of disinfectants.

1. Certified that medicines have no cheaper and effective substitute.
2. Certified that the treatment given was indoor/outdoor.
3. Certified that the price claimed is reasonable.
4. Certified that the medicines are not in the nature of tonics or food or vitamins etc., the cost of which is not reimbursable in the Govt. orders issued on this subject from time to time.
5. He/she is suffering from \_\_\_\_\_ (in capital letters).

Sr. No.	Name & Quantity of medicines (in capital letters)	Outdoor ticket No. & Date on which prescribed	Date on which actually purchased	Price


Countersignature & Designation of  
Medical Supdt./SMO/Authorized Doctor  
of the College

Signature and Designation  
Authorized Medical Attendant/Officer

Name in Capital letters \_\_\_\_\_  
(with Stamp)

Name in Capital letters \_\_\_\_\_  
(with Stamp)

Countersigned

Senior Medical Officer  
Campus Hospital,  
CCSHAU, Hisar.

**MEDICAL REIMBURSEMENT FORM**

In case of Indoor Treatment:-

Certified that the medicines claimed in this Bill are as per bed (Ticket No. \_\_\_\_\_) relates to the case.

Signature & stamp of the Authorised Medical  
Attendant/ Officer

Certified that:

1. The medicines have actually been purchased by me during the course of the treatment.
2. I am living in house No. \_\_\_\_\_
3. In case of Wife/Children:  
That the patient Mr./Mrs. \_\_\_\_\_ is my \_\_\_\_\_ and he/she is wholly dependent upon me and is residing with me and he/ she is unmarried and unemployed ( in case Sons/Daughters)

4. For Parents only:

- i) Parents as mentioned above, are wholly dependent upon me and have no other source of income except that the monthly income of my parents not exceed Rs.3500/- pm.
5. In case Spouse is working
  - a) Certified that my wife/husband is not getting any fixed medical allowance from any source.
  - b) Certified that my wife/husband is employed and is not getting medical reimbursement from any other source. An affidavit to this effect has already been furnished.
  - c) Certified that I am not adhoc employee and am working on Regular basis.

Signature of the Claimant

\_\_\_\_\_  
\_\_\_\_\_  
(Name & Designation in Capital Letters)

Place \_\_\_\_\_

Dated \_\_\_\_\_

CCS HARYANA AGRICULTURAL UNIVERSITY, HISAR  
Form for Reimbursement of Medical Charges

Form AU 5/12  
(Referred to in Rule 5.14)

Sr. No.	Name & relationship of the patient with the Univ. employee (along with passport size photograph)	Disease diagnosed by the Authorized Medical Officer	Name of medicine on a/c of which the expenditure was incurred	Amount of the bill (Rs.)	Place of posting	Reason for incurring expenditure at place other than the place of duty/posting	Period of treatment
1.	2. Name of patient Relationship with the Univ. employee	3.	4.	5.	6.	7.	8.
Above particulars attested HOD/Office Countersigned CMO	Photograph of the patient						

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Certified that :

- i) Parents as mentioned above, are wholly dependent upon me and have no other source of income except that the monthly income of my parents not exceed Rs.750/-
- ii) They reside with me at the place of my duty.
- iii) The medicines purchased have been fully used.
- iv) Registered No. of the Medical Practitioner is
- v) In case Spouse is working
  - a) Certified that my wife/husband is not getting any fixed medical allowance from any source.
  - b) Certified that my wife/husband is employed and is not getting medical reimbursement from any other source. An affidavit to this effect has already been furnished.

Certified that the medicines as detailed herein are not available in the Campus Dispensary and are admissible under the Punjab Govt. Medical Attendance Rules, 1940.

Medical Officer  
CCS Haryana Agril. University

Note : 1. Prescription should indicate :

- a) No. of the Regd. Medical Practitioner.
  - b) Name of the Medicine in legible handwriting.
  - c) Quantity of the medicine to be purchased from the market.
2. Cash Memo/Vouchers should be duly verified and attested by the employee concerned in token of payment having been made.
  3. Name of the medicine to be given in capital letters on the reserve side of the voucher.
  4. Sanction of the competent authority to be enclosed.

Signature of the employee  
(with date)  
Counter Signature .....

Designation