Annexure III

[See Rule 12 (3)(d)]]

Declaration to be signed by the Government Servant

I hereby declare that I have not at any time during my entire service claimed refund in respect of dentures for one jaw/both jaws for me/my*.....Sri/Smt.**.....who is a member of my family and will not claim in future.

* Here write the relationship. ** The name of the member of the family.

Signature of the Head of Office *Signature of the Government Servant*

Place:
Date:

ANNEXURE IV

[See Rule 13 (2)]

Declaration to be signed by the Government Servant

I hereby declare that this is the first/second time during my entire service that I have claimed refund in respect of Hearing Aid for me /my **.....

Shri/Smti.....who is a member of my family and will not claim after the second time in the future.

* Here write the relationship
* The name of the member of the family

Signature of the Head of Office *Signature of the Government Servant.*

Place:
Date:

ANNEXURE V

[See Rule 14 (Note)]

I hereby declare that this is the first/second/third time that I have claimed refund in respect of spectacles for me/my*..... Sri/Smt **.....who is a member of my family and will not claim after the third time in the future.

* Here write the relationship * * The name of the member of the family

Signature of the Head of Office *Signature of the Government Servant.*

Place:
Date:

ANNEXURE VII
[See Rule 16 (3)]

I Shri/Smti.....do hereby undertake to return the CPAP/BIPAP machine to the Department concerned after its utility is over.

Signature of the Head of Office *Signature of the Government Servant.*

ANNEXURE VIII
[See Rule 17 (9)]

I hereby declare that this is the first/second/third cycle that I have claimed refund in respect of IVF treatment for me/my wife, Smti ..... and will not claim after the third cycle in future.

Signature of the Head of Office *Signature of the Government Servant.*

Place:
Date:

ANNEXURE-XIII

[See Rule 27 (1) (c)] and Rule 29 (1)

Declaration to be signed by the Government Employees

Regarding particulars of a dependant under Rule 3 (7) of the Meghalaya Medical Attendance Rules, 2020 as applicable:-

Rules, 2020 as applicable:-

1. In case of **PARENTS**, please refer to Rule 3 (7) (b)
   I declare that Shri/Smti. .....who is my (relationship).....resides with me at (complete address)..... and is wholly dependent on me financially.
2. In case of **CHILDREN**, please refer to Rule 3 (7) (c)
   I declare that Shri/Smti. .....who is my (relationship).....was born on ..... And that he/she has no income of his/her own.
3. In case of PERMANENT DISABILITY, please refer to Rules 3 (7) (d)
   I declare that Shri/Smti. ..... who is my (relationship).....is suffering from permanent disability, was born on ..... and has no income of his/her own and is wholly dependent on me financially.
4. In case of CHRONIC DISEASES, please refer to Rule 3 (7) (e)/Annexure-I
   I declare that Shri/Smti. .....who is my (relationship)..... is suffering from.....and has no income of his/her own and is wholly dependent on me financially.

Place:

Signature of Declarant

Date:

Full Name:
Designation:
Office employed:

In case of pensioner: Pension Payment Order (P.P.O) No.....
Amount of Basic Pension Rs.....

Signature of Head of Office
(Certifying as per record available in the Government employee's Service Sheet)

N.B.: Column/paragraph not applicable should be struck off.

ANNEXURE - XIV

[See Rule 27(2) (c-ii)] and Rule 29(1)

To,

The .....

.....

Sub :- Final Medical reimbursement bill for medical treatment.

Sir,

I am to submit herewith the reimbursement claim/refund in connection with medical reimbursement claim of Shri./Smti.....At..... (Name of hospital) as per particulars given below:

(1) Full Name of the claimant.....

(2)

a. In case of serving Govt. Employee:

i. Designation and address of Office where employed.....

ii. Basic Pay and Ward Entitlement.....

OR

b. In case of pensioner:

i. Pension Payment Order (P.P.O): Number.....

ii. Amount of Basic pay before Retirement..... Ward Entitlement.....

(3)

a. Relationship of patient with the applicant if applicant is not the patient.....

b. Name of the patient.....

c. Age of the patient.....

(4) Whether the treatment was undertaken on the advice of the Authorized Medical attendant or whether the prior approval of the Director of Health Services was obtained.
If so, Referral Medical Certificate/Emergency Certificate issued by the authorized signatory of the treating institution as the case may be/Letter conveying approval for medical treatment, should be attached.

(5) Details of Medical Advances drawn; due to be regularized:

i. Amount drawn & date of drawal Rs.....

ii. Office from which drawn.....

iii. Amount already refunded. If any Rs.....

(6) Also enclosed are the following:

i. Essentiality Certificate with Bills/Cash memos duly listed showing

a. Serial number.....

b. Bill/ Cash memo number & date.....

c. Amount Certified by "Authorized Medical Attendant) /Authority of Treating Institution.....

ii. Total amount. Rs.....

(7) Claim/Refund. Rs.....

Place .....Date .....

Yours faithfully

Signature of the
Head of Office

Applicant

ANNEXURE –XV

[See Rule 29 (3)]

ESSENTIALITY CERTIFICATE

CERTIFICATE – A

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

Certificate granted to Mrs./Mr./Miss ..... Wife/Son, Daughter of Mr./Mrs./Miss.....employed in the .....

I Dr. ..... treating doctor/ authorized.

Signatory of the treating Hospital hereby certify:-

- That the patient is suffering from..... and has been under my treatment for. .....from ..... to ..... at the ..... Hospital and that the under mentioned medicines prescribed by me in this connection were essential for recovery/prevention of serious deterioration in the condition of the patient. The medicine are not stocked in .....(name of the hospital) for supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available not preparation which are primarily food, toilets or disinfectants.

Name of Medicines	Price.
1.....	.....
2.....	.....
3.....	.....
4.....	.....

- Hospital service charges
- Investigation
- Consultation Fees.
- Surgical procedure (if any)

(c) Others

Rates

Treating doctor/ Authorised Signatory of Treating Hospital.

Place:

Date:

ANNEXURE –XVI

[See Rule 29 (3)]

ESSENTIALITY CERTIFICATE

CERTIFICATE- B

(To be completed in the case of patients WHO ARE ADMITTED to Hospital for treatment)

Certificate granted to Mrs./Mr./Miss .....Wife/ Son/ Daughter of Mr./Mrs./Miss.....employed at .....

I Dr. .....treating doctor/authorized Signatory of the treating Hospital hereby certify

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

(*Name of the medical officer*) on my advice;

(b) That the patient has been under treatment at .....and that the under mentioned medicines prescribed by me in this connection were essential for recovery/prevention of serious deterioration in the condition of the patient. The medicine are not stocked in .....(*name of the hospital*) for supply to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available not preparation which are primarily food, toilets or disinfectants.

NAME OF MEDICINES	**Price**
1.....	.....
2.....	.....
3.....	.....
4.....	.....
5.....	.....

(c) Hospital service charges

	Rates
1. Investigations	.....
2. Consultation Fees.	.....
3. Surgical procedure (if any)	.....
4. Accommodation Charges.	.....

(d) Others

Place:

Date:

Treating doctor/Authorised
Signatory of Treating Hospital

Note: Certificates not applicable should be struck off. Certificate (B) is compulsory and must be filled in by the Medical Officers in all cases.