N.B.- Separate Form should be used for each patient.

NATIONAL INSTITUTE OF TECHNOLOGY
KURUKSHETRA- 136119

ESSENTIALITY CERTIFICATE

1. I certify that Mrs./Mr./Miss. .....wife/son/daughter of Shri ..... employed in NIT Kurukshetra has been under my treatment at NIT Kurukshetra Hospital/ My consulting Room, that the undermentioned medicines prescribed by me in this connection were absolutely essential for the treatment and recovery/ prevention of serious deterioration in the condition of the patient. The medicines were not stocked, in the ..... (name of hospital) for supply to entitled patient and don't include proprietary preparations for which cheaper substitute of equal therapeutic value are available for preparations which are primarily foods, toilets or disinfectants.
2. Certified that the treatment as in patient was necessary.
3. Certified that medicines charged have no cheaper effective substitute.
4. Period of treatment from ..... to .....
5. Certified that the medicines are not in the natures of the tonic etc., and cost of which is not reimbursable under the Govt. orders issued on the subject from time to time.
6. Certified that the price claimed is reasonable.
7. Certified that the medicines prescribed are not in the list of non- reimbursable medicines/ articles as per Central Govt. Rules.
8. Certified that the medicines purchased in this connection have actually been consumed during the period of treatment.
   He/ She was suffering from .....

Name of Medicine (in capital letters)	**Outdoor ticket no. & date of which prescribed**	**Date of which purchased**	**Price (`)**

Countersigned for ` .....

Signature & Designation
of the Authorized
Medical Officer

Senior Medical Officer
National Institute of Technology
Kurukshetra

Form of application for claiming refund of medical expenditure incurred in connection with medical attendance and / or treatment of employee of NIT Kurukshetra and their families.

1. Name & Designation of the employee	Name …… Designation …… Department ……
2. Pay of the employee according to the rules & other emoluments which should be shown Separately.	` ……
3. Place of Duty	……
4. Actual Residence Address	…… ……
5. Name of the patient and his/ her relationship to the employee (N.B.) in the case of children state age also	Name …… Relation ……
6. Place at which the patient fell ILL	……
7. Total Amount claimed	……
8. List of	……

DECLARATION TO BE SIGNED BY THE GOVERNMENT SERVANT

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

Date …….

Signature of the Institute Employee
and office to which attached

IN CASE OF DEPENDENT PARENTS

Certified that my father or mother, as the case may be in solely dependent on me and that he / she has no source of income of his/ her own whatsoever. He/ She has been residing with me.

Date …….

Signature of the Institute Employee
and office to which attached