

**ESSENTIALITY CERTIFICATE - "A"**

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

CERTIFICATE GRANTED TO Mr./Dr/Ms \_\_\_\_\_  
 wife/husband/daughter/son/father/mother of Mr/Dr/Ms \_\_\_\_\_  
 employed in the Directorate of Oilseeds Research, Hyderabad-500 030.

**CERTIFICATE**

- a) I, Dr. \_\_\_\_\_ hereby certify that, I charged and received Rs. \_\_\_\_\_ for \_\_\_\_\_ consultations on \_\_\_\_\_ (dates to be given) at my consulting room/at the residence of the patient.
- b) That I charged and received Rs. \_\_\_\_\_ for administering \_\_\_\_\_ intra-muscular/subcutaneous injections on \_\_\_\_\_ (dates to be given at my consulting room/the residence of the patient).
- c) That the injections administered were not/were for immunising or prophylactic purpose.
- d) That the patient has been under treatment at \_\_\_\_\_ hospital/my consulting room and that the undermentioned 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 the hospital) for supply of private patients and do not include proprietary preparations for which cheaper substances of equal, therapeutic value are available nor preparations which are primarily food, toilets or disinfectants.

Sl. No.	Name of medicines (in block letters)	Quantity	Price

- e) that the patient si/was suffering from \_\_\_\_\_ and is/was under my treatment from \_\_\_\_\_ to \_\_\_\_\_.
- f) that the patient is/was not given pre-natal or post-natal treatment.
- g) that the X-Ray, laboratory test, etc., for which an expenditure of Rs. \_\_\_\_\_ was incurred was necessary and were undertaken on my advice at \_\_\_\_\_ (name of the laboratory/hospital).
- h) that I referred this patient to Dr. \_\_\_\_\_ for specialist consultation and that the necessary approval of the \_\_\_\_\_ (name of the Chief Admn).
- i) that the patient did not required/required hospitalization.

Date: \_\_\_\_\_ Signature & Designation of the Medical Officer &  
 Name of the Hospital/Dispensary

Note : Certificate(s) is compulsory and must be filled in by Medical Officer

**FORM OF APPLICATION FOR CLAIMING REFUND OF MEDICAL EXPENSES INCURRED IN CONNECTION WITH MEDICAL ATTENDANCE AND OR TREATMENT OF CENTRAL GOVERNMENT SERVANTS AND THEIR DEPENDENTS**  
(Separate form should be used for each patient)

1. Name & Designation of the Employee : \_\_\_\_\_
2. Weather married or unmarried : \_\_\_\_\_  
If married, whether the spouse is employed, if so, place of employment : \_\_\_\_\_
3. Office in which employed : DOR, Rajendranagar, Hyderabad
4. Pay of the Govt. Servant in the FR & any other emoluments : Pay Rs. \_\_\_\_\_ DA Rs. \_\_\_\_\_  
CCA Rs. \_\_\_\_\_ HRA Rs. \_\_\_\_\_
5. Actual Residential Address : \_\_\_\_\_  
\_\_\_\_\_
6. Name of the patient and his/her relationship to the Govt. Servant : Name : \_\_\_\_\_  
(NB : In the case of children state the age also) Relationship : \_\_\_\_\_
7. Place at which the patient fell : \_\_\_\_\_  
**Medical Attendance**
8. The Name & Designation of the Medical Officer consulted and the Hospital to which attached : \_\_\_\_\_  
\_\_\_\_\_
9. The number and dates of consultations & the fee paid for each consultation : No. \_\_\_\_\_  
Dates \_\_\_\_\_  
Fee paid : Rs. \_\_\_\_\_
10. The number & dates of injections and the fee paid for each injection : No. \_\_\_\_\_  
Dates \_\_\_\_\_  
Fee paid : Rs. \_\_\_\_\_
11. Whether consultations and/or were had at the hospital, at the consultation room of the Medical Officer or at the residence of the patient : \_\_\_\_\_
12. Charges for Pathological, Bacteriological, Radiological or other similar tests under taking during diagnosis indicating : Rs. \_\_\_\_\_
13. The name of the Laboratory/Hospital where the tests were undertaken : \_\_\_\_\_
14. Whether the tests were undertaken on the advise of the AMA if so, a certificate to that effect should be attached : Attached
15. Cost of Medicines purchased from the Market (Cash memos & essentiality certificates should be attached) : Rs. \_\_\_\_\_
16. Total Amount claimed : Rs. \_\_\_\_\_
17. List of enclosures : \_\_\_\_\_

**DECLARATION**

I hereby declare that the statement 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 incurred is wholly dependent upon me.

Date :

Signature of the Government Servant