

6.3.2 Institutional Policy document on providing financial support to teachers  
 Institutional Policy document on providing financial support to teachers

REGIONAL INSTITUTE OF EDUCATION, MYSORE 570 006.

APPLICATION FORM FOR ADVANCE FOR THE PURCHASE OF COMPUTER

01.	Name of the applicant	
02.	Applicant's Designation	
03.	District & Station	
04.	Basic Pay	
05.	Anticipated Price of Personal computer	
06.	Amount of advance required	
07.	Date of Entry into the council	
08.	Date of superannuation or retirement or date of expiry of contract in case of officer.	
09.	Number of instalment in which the advance is desired to be repaid.	
10.	Whether advance for similar purpose was obtained previously and is so, a) Date of drawl of the advance b) The amount of advance & Interest thereon still outstanding if any,	
11.	Whether the intention is to purchase a) A new or old personal computer. b) If the intention is to purchase personal computer through a person other than a regular or reputed dealer or agent, whether previous sanction of the competent authority has been obtained as required under rule 15(2) of the Central Services (Conduct) Rules 1955.	
12.	Whether the official is on leave or is about to proceed on leave. a) The date of commencement of leave. b) The date of expiry of leave.	
13.	Are any negotiations or preliminary enquiries being made so that delivery may be taken of the personal computer with one month from the date of drawl of the advance?	

a) Certified that the information given above is complete and true.

b) Certified that I have not taken delivery of the computer advance on Account of which I apply for the advance, that I shall complete negotiations for the purchase of pay finally and take possession of the Personal computer before the expiry of one month from the date

*Signature*

परिषद कर्मचारी तथा उनके परिवार की चिकित्सा या चिकित्सा उपस्थिति के संबंध में  
उठाए गए चिकित्सा संबंधी व्यय की वापसी के दावा करने संबंधी आवेदन प्रपत्र

Form of Application of Claiming Refund of Medical Expenses  
incurred in connection with Medical attendance and or treatment  
of Council Servants and their families.

टिप्पणी : प्रत्येक रोगी के लिए अलग प्रपत्र प्रयोग किया जाए ।

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

1. परिषद कर्मचारी का नाम और पदनाम स्पष्ट शब्दों में  
Name and designation of the  
Council Servant (In block letters)
2. कार्यालय जहाँ वह नियुक्त है ।  
Office in which employed
3. परिषद कर्मचारी की / के अन्तर्गत परिभाषित  
वेतन तथा / मूलभूत नियमों / अन्य परिलब्धियों  
हिन्हीं अलग से दिखाया जाये ।  
Pay of the Council Servants as  
defined in the Fundamental Rules,  
and any other emoluments which  
should be shown separately.
4. कार्य का स्थान  
Place of duty
5. वास्तविक आवासीय पता  
Actual residential address.
6. रोगी का नाम व उसके परिषद कर्मचारी  
के साथ संबंध  
Name of the Patient and his / her  
relationship to the Council Servant.  
अ. रोगी का नाम Name of the patient  
ब. संबंध Relationship  
(टिप्पणी : बच्चों के मामले में आयु भी लिखें)  
(N.B. : in case of children state age also)
7. वह स्थान जहाँ रोगी बीमार हुआ  
Place at which the patient fell ill
8. रोग की प्रकृति तथा अवधि  
Nature of illness and its duration
9. मांगी गई राशि का विवरण  
Details of amount claimed

10. मांगी गई कुल राशि  
Total amount claimed
11. दिनांक ..... को ली गई राशि  
को घटाएं रु .....  
Less advance taken on ..... Rs.
12. दावे की कुल राशि  
Net amount claimed
13. संलग्नकों की सूची  
List of enclosures

परिषद कर्मचारी द्वारा निम्न पत्र इस्ताक्षर करने हे।

**Declaration to be signed by the Council Servant**

मैं, एतद्वारा घोषणा करता हूँ कि इस आवेदन पत्र दिये विवरण मेरी जनकारी व विश्वास में पूर्ण सत्य है तथा व्यक्ति के लिए चिकित्सा व्यय किया गया, वह पूर्ण रूप पर अक्षित है / था

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.

तिथि : .....  
Date : .....

परिषद कर्मचारी के हस्ताक्षर  
एवं कार्यालय जिससे सम्बन्ध है  
Signature of the Council Servant  
and Office to which attached

रुपयों के लिए प्रति हस्ताक्षरित  
Countersinged for Rupees.....

लेखा अधिकारी  
Accounts Officer  
क्षेत्रीय शिक्षा संस्थान  
Regional Institute of Education  
Mysore

प्रशासन अधिकारी  
Administrative Officer  
क्षेत्रीय शिक्षा संस्थान  
Regional Institute of Education  
Mysore

प्रचार्य  
Principal  
क्षेत्रीय शिक्षा संस्थान  
Regional Institute of Education  
Mysore

श्री/श्रीमती/कृ .....

श्री/आत्मज/आत्मजा श्री ..... को दिया गया प्रमाण पत्र

Certificate granted to Mr./Mrs./Miss.....

Wife/son/daughter of Mr./Mrs./Miss.....

Employed in the.....

## प्रमाण - पत्र "क" CERTIFICATE - A

(सिर्फ उन रोगियों के संबंध में भरना है उपचार के लिए भरती नहीं हुए हैं  
(To be completed in the case of patients who are not admitted to hospital for treatment.)

मैं डा ..... प्रमाणित करता हूँ कि:

1. Dr..... hereby certify:

(क) मैं अपने परामर्श कक्ष/रोगी के आवास पर दिनांक ..... को परामर्श देने के  
निमित्त ..... रुपये की मांग की व उन्हें प्राप्त किया।

that I charged and received Rs..... for.....  
consultation on ..... (dates to be given) at my consulting room/  
at the residence of the patient.

(ख) मैंने अपने परामर्श कक्ष/रोगी के आवास पर दिनांक ..... को अन्तःशिक्षा / त्ः  
पेशी / अवत्वचीय इंजेक्शन लगाने के निमित्त ..... रुपये की मांग की व उन्हें प्राप्त किया।

that I charged and received Rs..... for administering  
..... intra muscular injections or subcutaneous on  
..... (dates to be given) at my Consulting room / the residence of the patient

(ग) लगाये गये इंजेक्शन प्रतिरक्षित या रोग निरोधक उद्देश्य से थे / नहीं थे।

that the injections administered were/ were not for immunising or prophylactic purposes.

(घ) रोगी ..... अस्पताल से मेरे परामर्श कक्ष पर उपचार करवा रहा है तथा इस सम्बन्ध में मैंने जो  
विम्वलिखित दवाइयें निर्दिष्ट की हैं वे रोगी के स्वास्थ्य में सुधार/गंभीर गिरती हुई दशा को रोकने के लिए अत्यावश्यक थीं। दवाएं  
बहिरंग रोगियों को देने के लिए ..... अस्पताल में उपलब्ध नहीं हैं और जो समान परिमाण के पदार्थ  
सस्ते में उपलब्ध हैं, इस अधिस्वामिक औषधि के निर्माण में सम्मिलित नहीं हैं, जिनमें मूल भोजन, स्वच्छक या पीडक जन्तुनाशक निर्माण  
सम्मिलित हैं।

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 hospt.) for supply to private patients and not included  
proprietary preparations for which cheaper substance of equal therapeutic value are available  
nor preparations which are primarily foods, toilets or disinfectants.

क्र स Sl.No.	दवाइयों के नाम Name of Medicines	मूल्य Price Rs.
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

योग  
Total \_\_\_\_\_

- (ड) रोगी.....रोग से पीड़ित है/था और दिनांक.....तक मेरी चिकित्सान्तर्गत है/था।  
that the patient is/was suffering from .....and is/was under my treatment from .....to.....
- (च) रोगी का पूर्व या प्रसवोत्तर उपचार नहीं किया गया है / था  
that the patient is/was given pre-natal or treatment
- (छ) एक्स रे, प्रयोगशाला परीक्षण आदि जिन पर.....रु खर्च हुए.....आवश्यक थे तथा.....अस्पताल से मेरी सलाह पर कराए गये।  
that the X-ray, laboratory test etc., for which expenditure of Rs.....was incurred was necessary and were under taken on..... my advice at.....(Name of hospital or laboratory)
- (ज) मैंने रोगी को विशेष परामर्श के लिए डा.....के पास भेजा और इसके लिए.....कि स्विकृति जो नियमान्तर्गत आवश्यक है ले ली थी।  
that I referred the patient to Dr.....for specialist consultation and that the necessary approval of the.....(Name of the chief administrative Medical Officer of the State) as required under the rules was obtained.
- (झ) रोगी को अस्पताल में भर्ति करना आवश्यक नहीं था।  
That the patient did not require / required hospitalisation.
- (ञ) प्रमाणित किया जाता है कि मैंने क्रम कि गई दवाइयों का अपने दिए गए नस्खे के अनुसार सत। आपन कर लिया है  
Certified that I have verified the medicines purchased which are in accordance with the prescription given by me.

दिनांक :  
Dated :

अस्पताल के चिकित्सा अधिकारि के  
हस्ताक्षर तथा पदनाम  
Signature & Designation of the Medical  
Officer of Hospital

परिषद कर्मचारी तथा उनके परिवार की चिकित्सा या चिकित्सा उपस्थिति के संबंध में  
उठाए गए चिकित्सा संबंधी व्यय की वापसी के दावा करने संबंधी आवेदन प्रपत्र

Form of Application of Claiming Refund of Medical Expenses  
incurred in connection with Medical attendance and or treatment  
of Council Servants and their families.

टिप्पणी : प्रत्येक रोगी के लिए अलग प्रपत्र प्रयोग किया जाए ।

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

1. परिषद कर्मचारी का नाम और पदनाम स्पष्ट शब्दों में  
Name and designation of the  
Council Servant (In block letters)
2. कार्यालय जहाँ वह नियुक्त है ।  
Office in which employed
3. परिषद कर्मचारी की / के अन्तर्गत परिभाषित  
वेतन तथा / मूलभूत नियमों / अन्य परिलब्धियों  
हिन्हीं अलग से दिखाया जाये ।  
Pay of the Council Servants as  
defined in the Fundamental Rules,  
and any other emoluments which  
should be shown separately.
4. कार्य का स्थान  
Place of duty
5. वास्तविक आवासीय पता  
Actual residential address.
6. रोगी का नाम व उसके परिषद कर्मचारी  
के साथ संबंध  
Name of the Patient and his / her  
relationship to the Council Servant.  
अ. रोगी का नाम Name of the patient  
ब. संबंध Relationship  
(टिप्पणी : बच्चों के मामले में आयु भी लिखें)  
(N.B. : in case of children state age also)
7. वह स्थान जहाँ रोगी बीमार हुआ  
Place at which the patient fell ill
8. रोग की प्रकृति तथा अवधि  
Nature of illness and its duration
9. मांगी गई राशि का विवरण  
Details of amount claimed

10. मांगी गई कुल राशि  
Total amount claimed
11. दिनांक ..... को ली गई राशि  
को घटाएं रु .....  
Less advance taken on ..... Rs.
12. दावे की कुल राशि  
Net amount claimed
13. संलग्नकों की सूची  
List of enclosures

परिषद कर्मचारी द्वारा निम्न पत्र इस्ताक्षर करने हे।

**Declaration to be signed by the Council Servant**

मैं, एतद्वारा घोषणा करता हूँ कि इस आवेदन पत्र दिये विवरण मेरी जनकारी व विश्वास में पूर्ण सत्य है तथा व्यक्ति के लिए चिकित्सा व्यय किया गया, वह पूर्ण रूप पर अक्षित है / था

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.

तिथि : .....  
Date : .....

परिषद कर्मचारी के हस्ताक्षर  
एवं कार्यालय जिससे सम्बन्ध है  
Signature of the Council Servant  
and Office to which attached

रुपयों के लिए प्रति हस्ताक्षरित  
Countersinged for Rupees.....

लेखा अधिकारी  
Accounts Officer  
क्षेत्रीय शिक्षा संस्थान  
Regional Institute of Education  
Mysore

प्रशासन अधिकारी  
Administrative Officer  
क्षेत्रीय शिक्षा संस्थान  
Regional Institute of Education  
Mysore

प्रचार्य  
Principal  
क्षेत्रीय शिक्षा संस्थान  
Regional Institute of Education  
Mysore

श्री/श्रीमती/कृ .....

श्री/आत्मज/आत्मजा श्री ..... को दिया गया प्रमाण पत्र

Certificate granted to Mr./Mrs./Miss.....

Wife/son/daughter of Mr./Mrs./Miss.....

Employed in the.....

## प्रमाण - पत्र "क" CERTIFICATE - A

(सिर्फ उन रोगियों के संबंध में भरना है उपचार के लिए भरती नहीं हुए हैं  
(To be completed in the case of patients who are not admitted to hospital for treatment.)

मैं डा ..... प्रमाणित करता हूँ कि:

1. Dr..... hereby certify:

(क) मैं अपने परामर्श कक्ष/रोगी के आवास पर दिनांक ..... को परामर्श देने के  
निमित्त ..... रुपये की मांग की व उन्हें प्राप्त किया।

that I charged and received Rs..... for.....  
consultation on ..... (dates to be given) at my consulting room/  
at the residence of the patient.

(ख) मैंने अपने परामर्श कक्ष/रोगी के आवास पर दिनांक ..... को अन्तःशिक्षा / त्ः  
पेशी / अवत्वचीय इंजेक्शन लगाने के निमित्त ..... रुपये की मांग की व उन्हें प्राप्त किया।

that I charged and received Rs..... for administering  
..... intra muscular injections or subcutaneous on  
..... (dates to be given) at my Consulting room / the residence of the patient

(ग) लगाये गये इंजेक्शन प्रतिरक्षित या रोग निरोधक उद्देश्य से थे / नहीं थे।

that the injections administered were/ were not for immunising or prophylactic purposes.

(घ) रोगी ..... अस्पताल से मेरे परामर्श कक्ष पर उपचार करवा रहा है तथा इस सम्बन्ध में मैंने जो  
विम्वलिखित दवाइयें निर्दिष्ट की हैं वे रोगी के स्वास्थ्य में सुधार/गंभीर गिरती हुई दशा को रोकने के लिए अत्यावश्यक थीं। दवाएं  
बहिरंग रोगियों को देने के लिए ..... अस्पताल में उपलब्ध नहीं हैं और जो समान परिमाण के पदार्थ  
सस्ते में उपलब्ध हैं, इस अधिस्वामिक औषधि के निर्माण में सम्मिलित नहीं हैं, जहाँ उसमें मूल भोजन, स्वच्छक या पीडक जन्तुनाशक निर्माण  
सम्मिलित हैं।

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 hospt.) for supply to private patients and not included  
proprietary preparations for which cheaper substance of equal therapeutic value are available  
nor preparations which are primarily foods, toilets or disinfectants.



क्र स Sl.No.	दवाइयों के नाम Name of Medicines	मूल्य Price Rs.
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

योग  
Total \_\_\_\_\_

- (ड) रोगी.....रोग से पीड़ित है/था और दिनांक.....तक मेरी चिकित्सान्तर्गत है/था।  
that the patient is/was suffering from .....and is/was under my treatment from .....to.....
- (च) रोगी का पूर्व या प्रसवोत्तर उपचार नहीं किया गया है / था  
that the patient is/was given pre-natal or treatment
- (छ) एक्स रे, प्रयोगशाला परीक्षण आदि जिन पर.....रु खर्च हुए.....आवश्यक थे तथा.....अस्पताल से मेरी सलाह पर कराए गये।  
that the X-ray, laboratory test etc., for which expenditure of Rs.....was incurred was necessary and were under taken on..... my advice at.....(Name of hospital or laboratory)
- (ज) मैंने रोगी को विशेष परामर्श के लिए डा.....के पास भेजा और इसके लिए.....कि स्विकृति जो नियमान्तर्गत आवश्यक है ले ली थी।  
that I referred the patient to Dr.....for specialist consultation and that the necessary approval of the.....(Name of the chief administrative Medical Officer of the State) as required under the rules was obtained.
- (झ) रोगी को अस्पताल में भर्ति करना आवश्यक नहीं था।  
That the patient did not require / required hospitalisation.
- (ञ) प्रमाणित किया जाता है कि मैंने क्रम कि गई दवाइयों का अपने दिए गए नस्खे के अनुसार सत। आपन कर लिया है  
Certified that I have verified the medicines purchased which are in accordance with the prescription given by me.

दिनांक :  
Dated :

अस्पताल के चिकित्सा अधिकारि के  
हस्ताक्षर तथा पदनाम  
Signature & Designation of the Medical  
Officer of Hospital

**Annexure**

**Form of declaration to be submitted by the OBC candidate**  
**(in addition to the community certificate)**

I .....Son/daughter of Shri.....resident of village/ town/ city  
.....district.....State.....hereby declare that I belong to the  
.....community which is recognized as a backward class by the Government of India for the  
purpose of reservation in services as per orders contained in Department of Personnel and Training Office  
Memorandum No 36012/22/93-Estt. (SCT) dated 8-9-1993. It is also declared that as on closing date , I do not  
belong to persons/ sections (Creamy Layer) mentioned in column 3 of the Schedule to the above referred  
Office Memorandum dated 8-9-1993, O.M. No. 36033/3/2004-Estt. (Res.) dated 9th March, 2004, O.M. No.  
36033/3/2004-Estt. (Res.) dated 14th October, 2008, OM No. 36033/1/2013-Estt. (Res.), dated: 27<sup>th</sup> May, 2013  
and OM No. 36033/1/2013-Estt. (Res.), dated: 13<sup>th</sup> Septmber2017.

Signature: \_\_\_\_\_  
Full Name: \_\_\_\_\_  
Address: \_\_\_\_\_

<p>34.</p>	<p>Applicants serving under Government, Quasi-Government, Public Sector Undertaking and Autonomous Organizations should apply through proper channel and submit at the time of online application the permission letter from their present employer as per following format :-</p> <p>Mr./Mrs./Ms. _____ is working in this organization in the capacity as _____ from _____ to _____ and the institution/ organization has no objection to his/her candidature being considered for the post of _____ applied by him/her in NCERT.</p> <p>Place: _____ Signature of Head of the Institution  Date: _____ Name: _____  Fax: _____ Designation: _____  E-mail: _____ Address: _____</p> <p style="text-align: right;">(Office Seal)</p>
<p>35.</p>	<p>In case of any query related to applying online, you may contact over telephone number 011-26592153/207 for software/technical support and 01126592187 for general information respectively upto closing date of filling up of online application. You may also send the same to email id i.e. <a href="mailto:advertisement172@gmail.com">advertisement172@gmail.com</a>. It may be noted that the queries other than online application will not be entertained at all.</p>

Under Secretary,  
Recruitment Section-I

# Regional Institute of Education, Mysore - 570 006

## APPLICATION FOR LEAVE OR EXTENSION OF LEAVE

1. Name of Applicant.
2. Post Held.
3. Department / Office / Section.
4. Pay
5. House rent and other compensatory allowance drawn in the present post.
6. Nature and period of leave applied for and date from which required.
7. Sundays and Holidays, if any, proposed to be prefixed / suffixed to leave.
8. Grounds on which leave is applied for.
9. Date and return from last leave, and the nature and period of that leave.
10. I proposed / do not propose to avail myself of leave travel concession for the block years..... during the ensuing leave.
11. Address during leave period.
12. In the event of my resignation or voluntary retirement from service, I undertake to refund :-
  - i) the difference between the leave salary drawn during commuted leave and that admissible during half-pay leave which would not have been admissible had sub-rule (1) of rule 30 not been applied
  - ii) the leave salary drawn during 'leave not due' which not have been admissible, had-sub-rule (1) of rule 31 not been applied

Score out whatever be not applicable

Date :

*Signature of Applicant*

13. Remarks and / or recommendation of the Controlling Officer

Signature  
Designation.

[P.T.O.]

is admissible under rule..... of the Central Civil  
Services (leave) Rules, 1972

Date :

Signature  
Designation

15. Orders of the authority competent to grant leave.

Date :

Signature  
Designation

If the applicant is drawing any compensatory allowance, it should also be indicated in the orders on the expiry of leave, the Government servant is likely to return to the same post or to another post carrying similar allowance.

श्री/ श्रीमती/कु \_\_\_\_\_  
पत्नी/आत्मज/आत्मजा श्री \_\_\_\_\_ को दिया गया प्रमाण  
पत्र

Certificate granted to Mr./Mrs./Miss. \_\_\_\_\_  
wife/son/daughter of Mr./Mrs./Miss. \_\_\_\_\_  
Employed in the \_\_\_\_\_

प्रमाण-पत्र "क"  
CERTIFICATE - A

(सिर्फ उन रोगियों के संबंध में भरता है जो अस्पताल में उपचार के लिए भरती नहीं हुए हैं)

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

मैं, डा. \_\_\_\_\_ प्रमाणित करता हू कि :  
I, Dr. \_\_\_\_\_ hereby certify :

(क) मैं अपने परामर्श कक्ष/रोगी के आवास पर दिनांक \_\_\_\_\_ को परामर्श देने के  
निमित्त \_\_\_\_\_ रुपये की मांग की व उन्हें प्राप्त किया ।  
that I charged and received Rs. \_\_\_\_\_ for \_\_\_\_\_  
consultations on \_\_\_\_\_ (dates to be given) at my consulting room /  
at the residence of the patient.

(ख) मैंने अपने परामर्श कक्ष/रोगी के आवास पर दिनांक \_\_\_\_\_ को अन्त :शिक्षा / अन्त : पेशी/अवत्वचीय  
इंजेक्शन लगाने के निमित्त \_\_\_\_\_ रुपये की मांग की व उन्हें प्राप्त किया।  
that I charged and received Rs. \_\_\_\_\_ for administering  
\_\_\_\_\_ intra muscular injections or subcutaneous on  
\_\_\_\_\_ (dates to be given) at my consulting room / the residence of  
the patient.

(ग) लगाये गये इंजेक्शन प्रतिरक्षित या रोग निरोधक उद्देश्य से थे / नहीं थे ।  
that the injections administered were / were not for immunising or prophylactic purposes.

(घ) रोगी \_\_\_\_\_ अस्पताल में मेरे परामर्श कक्ष पर उपचार करवा रहा है तथा इस सम्बन्ध में मैंने जो  
विम्बलिखित दवाइयाँ निर्दिष्ट की हैं वे रोगी के स्वास्थ्य में सुधार/गंभीर गिरती हुई दशा को रोकने के लिए अत्यावश्यक थीं।  
दवाएं बहिरंग रोगियों को देने के लिए \_\_\_\_\_ अस्पताल में उपलब्ध नहीं हैं और जो समान परिमाण  
के पदार्थ सस्ते में उपलब्ध हैं, इस अधिस्वामिक औषधि के निर्माण में सम्मिलित नहीं हैं, न ही उसमें मूल भोजन स्वच्छक या पीड़क  
जन्तुनाशक निर्माण सम्मिलित हैं।  
that the patient has been under treatment at \_\_\_\_\_ (hospital) my con-  
sulting 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  
hospt.) for supply to private patients and not included proprietary preparations for which  
cheaper substance of equal therapeutic value are available nor preparations which are  
primarily foods, toilets or disinfectants.

क्र.सं. Sl.No.	दवाइयों के नाम Name of Medicines	मूल्य Price Rs.
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

योग  
Total

(ड) रोगी \_\_\_\_\_ रोग से पीड़ित है/था और दिनांक \_\_\_\_\_ तक मेरी चिकित्सान्तर्गत है/था।  
that the patient is/was suffering from \_\_\_\_\_ and is/was under my treatment from \_\_\_\_\_ to \_\_\_\_\_

(घ) रोगी का पूर्व या प्रसवोत्तर उपचार नहीं किया गया है /था  
that the patient is/was given pre-natal or treatment.

(छ) एक्स-रे, प्रयोगशाला परीक्षण आदि जिन पर \_\_\_\_\_ रु. खर्च हुए, \_\_\_\_\_ आवश्यक थे तथा \_\_\_\_\_ अस्पताल में मेरी सलाह पर कराए गए।  
that the X-ray, laboratory test etc. for which expenditure of Rs. \_\_\_\_\_ was incurred was necessary and were under taken on \_\_\_\_\_ my advice at \_\_\_\_\_ (Name of hospital or laboratory)

(ज) मैंने रोगी को विशेषज्ञ परामर्श के लिए डा. \_\_\_\_\_ के पास भेजा और इसके लिए \_\_\_\_\_ की स्वीकृति जो नियमान्तर्गत आवश्यक है ले ली थी।  
that I referred the patient to Dr. \_\_\_\_\_ for specialist consultation and that the necessary approval of the \_\_\_\_\_ (Name of the Chief Administrative Medical Officer of the State) as required under the rules was obtained.

(झ) रोगी को अस्पताल में भर्ती करना आवश्यक नहीं था।  
That the patient did not require / required hospitalisation.

(ञ) प्रमाणित किया जाता है कि मैंने क्रय की गई दवाइयों का अपने दिए गए नस्खे के अनुसार सत्यापन कर लिया है।  
Certified that I have verified the medicines purchased which are in accordance with the prescription given by me.

दिनांक :  
Dated :

अस्पताल के चिकित्सा अधिकारी के  
हस्ताक्षर तथा पदनाम  
Signature & Designation of the  
Medical Officer of Hospital

Certificate granted to Mr./Mrs./Miss.....  
wife/son/daughter of Mr. ....  
employed in the.....

**CERTIFICATE B**

(To be completed in the case of patients who are admitted to hospital for treatment).

**PART A**

(To be signed by the Medical Officer-in-charge of the.....  
.....case of the hospital).

I, Dr. ....hereby clarify :

(a) that the patient was admitted to hospital on the advice of/on my advice  
.....  
(Name of the Medical Officer)

(b) that the patient has been under treatment at.....  
.....

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.....for supply  
(Name of Hospital)

to private patients and do not include proprietary preparations for which cheaper substances of equal therapeutic value are available not preperations which are primarily foods, toilets or disinfectants.

Names of Medicines

Price

- 1
- 2
- 3
- 4
- 5

(c) That the injections administered were/were not for immunising or prophlactic purposes.

(d) That the patient is/was suffering from.....  
and is/was under my treatment from.....to.....



(e) That the X-ray, Laboratory tests etc., for which an expenditure of Rs. ...., was incurred were necessary and were undertaken on my advice at.....  
(Name of Hospital or Laboratory)

(f) That I called on Dr. ....for specialist consultation and that the necessary approval of the .....  
(Name of the Chief Administrative Medical Officer of the State)  
..... as required under the rules was obtained.

*Signature and Designation of the Medical Officer-in-charge of the case at the Hospital.*

**PART B**

I certify that the patient has been under treatment at.....  
.....  
Hospital and that the service of the special nurses, for which an expenditure of Rs. ....was incurred *vide* Bills and Receipts attached, were essential for the recovery/prevention of serious deterioration in the condition of the patient.

*Signature of the Medical Officer-in-charge of the case at the Hospital.*

**COUNTERSIGNED**

Medical Superintendent.....Hospital

I certify that the patient has been under treatment at the .....  
.....  
Hospital and that the facilities provided were the minimum which were essential for the patient's treatment.

*Medical Superintendent,*

Place : .....Hospital.

*N.B. :* Certificates not applicable should be struck off. Certificate (D) is compulsory and must be filled in by the Medical Officer in cases.