SPORTS AUTHORITY OF INDIA
JAWAHARLAL NEHRU STADIUM

APPLICATION FORM FOR CLAIMING REIMBURSEMENT OF MEDICAL EXPENSES

Name and Designation of the Employee : _____
Name and Patient and Relationship with the Employee : _____
Total Amount claimed in Figures : _____
In Words : _____

Name of the Doctor & Reg.No. : _____
List of Enclosures :

SN	Cash Memo No.	Date(s)	Amount	
			Rupees	Paise
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
	TOTAL:			

Signature of Employees

I hereby certify that the patient has been under treatment and above mentioned medicines were prescribed by me and are / were not supplied by the Hospital.

That the patient is /was suffering from _____ and is/was under my treatment from _____ to _____.

The claim is verified for _____ (Rupees _____)
Certificates applicable in case of hospitalization treatment only.

MEDICAL OFFICER

FOR OFFICE USE

1) Amount claimed so far : _____
2) Amount of the present claim : _____
3) Total Amount claimed including this claim. : _____
4) Certified that Shri / Smt./Km. _____ is the Son/ Daughter/ Wife / Father / Mother / of Shri / Smt./ Km. _____ as per the details of family available in the office. Who is employed in the Sports Authority of India _____.
5) The claim has been verified and passed for payment of Rs. _____ (Rupees _____).

This issue with the approval of Secretary, SAI.

ASSISTANT DIRECTOR (PERS)