



University of Colombo

(FOR OFFICE USE ONLY)

Medical Welfare Scheme - 2018
Surgical and Hospital Expenses Claim Form

EMP No. : Scheme I [] Scheme II [] Scheme III []

EMPLOYEE'S

- 1. Name (in full) :
2. Designation (describe fully)
3. Whether Academic/Academic Support/Administrative/Non-Academic:
4. Department: : Age:
5. Address :
6. Telephone No: (Official): (Residence): (Mobile):

(Please submit the form with all the bills pasted on the separate paper by entering the relevant register at the Student and Staff Welfare Branch. Also ensure that all the bills contain the dates and the seal of the Doctor.)

DEPENDANT – (Subject in respect of whom claim is made)

- 1. Name (in full)
2. Relationship

INJURY – please state

- 1. Date and place of Accident
2. Precisely how the Accident Occurred
3. Nature and Extent of Injuries

ILLNESS – please state

- 1. Nature or Description of illness:
2. Date of Commencement of illness:
3. Date of first consultation regarding this illness:
4. Name & the address of doctor who was first consulted

PERIOD OF HOSPITALIZATION

From To

GENERAL INFORMATION

Table with 2 columns and 5 rows containing general information questions about previous illnesses, medical attention, insurance claims, and current treatment details.

c) Name of hospital concerned if any d) Name of any Consulting Specialists Whose recommended treatment you or have been receiving giving details of the treatment concerned and other Specialist services received.	
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I HEREBY DECLARE that I have received the injuries above described and suffering from illness as above described, and I claim reimbursement under the above Medical Welfare Scheme in respect thereof. I hereby warrant that the above statements and facts are true and that I have not withheld from the University any material information connected with this claim.

Witness (Signature)
Date Date

Total amount of all receipts (bills) : Rs:.....

TO BE COMPLETED BY THE PATIENT’S GENERAL PRACTITIONER/ SURGEON

- a) Name of patient (in full)
- b) Condition that necessitated investigation or treatment
- c) General practitioner by whom referred
- d) Diagnosis of disease
- e) Details of treatment or operation and prognosis
- f) Was the onset of illness acute, sub acute or chronic?
- g) For how long would the patient have suffered from these symptoms and signs?.....
- h) Period of hospitalization
Date of admission..... Date of discharge
- i) State approximately when, in your opinion the ailment could have BEGUN or been CONTRACTED by the patient

I certify that I am the General Practitioner/ Surgeon of the patient of the referred to above, and that I approved the services for which this claim is made.

Date:
Signature of the Practitioner/ Surgeon/ Specialist who attended on this patient for this ailment

Name of Practitioner/ Surgeon:.....

Qualifications:.....

Address:.....

T.Phone No.:.....

(To be completed by surgeon all cases as surgical and surgical treatment)
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Recommendation of the Head of the Department

After considering the medical certificates, receipts and other information provided by the applicant in relation to the medical treatment received, I recommend the re-imbursement of total expenses /an amount of Rs.of total expenses incurred by him/her in this connection.

Date:
Signature of the Head of the Department (Seal)

The information given by the applicant and the document attached herewith have been checked and recommended/ not recommended reimbursement of the total expenses.

Date:
Academic Staff member of the Medical Faculty (Seal)