APPLICATION FOR REIMBURSEMENT OF MEDICAL EXPENSES.

OPD TREATMENT / SPECTACLES

EMP. No: ...........................................

Scheme I ........................................

Scheme II .......................................

Scheme III .......................................

Name of Applicant: ..................................................................................................................

Designation: ..........................................................................................................................

Department: ..........................................................................................................................

Telephone No (Office): ..........................................................................................................

Mobile: .................................................................................................................................

Age: ..................................................................................................................................

Whether married/Single: ...........................................................................................................

(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.)

Re. No Name/Names of Patient/s who has received treatment Relationship to Applicant Name of the Doctor who treated Date/Dates on which treatment was received.

1. ...........................................................................................................................................

2. ...........................................................................................................................................

3. ...........................................................................................................................................

4. ...........................................................................................................................................

Details regarding bills (Medical/Hospital/Pharmacies)
(While the Doctor’s prescription should be annexed to bills obtained from Pharmacies, all required documents to substantiate the information provided below should be submitted along with the application form.)

<table>
<thead>
<tr>
<th>No</th>
<th>Bill No.</th>
<th>Purpose</th>
<th>Date of issue of the bills</th>
<th>Amount Rs.</th>
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<tbody>
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<td>1.</td>
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</tbody>
</table>

Total

I hereby state that I have claimed Rs. ............................. as Medical expenses as aforesaid and that the information provided in the claim form are true and accurate.

Date: ..........................................................  Signature of Applicant

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)


<table>
<thead>
<tr>
<th>ප්‍රතිලාභ කාලය</th>
<th>ඉලේලුම් පත්‍ර සමඟ</th>
<th>විවාහක/අවිවාහක</th>
<th>ක්‍රමය</th>
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<td>3.</td>
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<td>III</td>
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<td>4.</td>
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</tr>
</tbody>
</table>

විවාහක/අවිවාහක

1. ජනමායිකයාව  සඳහා පිළිබඳ විස්තර (බිලේපත් / ආරෝග්‍යාලා / ෙබෙහත් ශාලා)

ඉහත සඳහනේ පරිදි මා විසිනේ රුපියලේ ඔහු / ඇය විසිනේ ෛවද්‍ය ප්‍රතිකාර සඳහා දරන ප්‍රශුරේණය කිරීම මම නිරේෙදේශ කරමි/ෙනාකරමි.

දිනය       ...........................................       .........................................................