

**UNIVERSITY OF COLOMBO  
MEDICAL WELFARE SCHEME**

(FOR OFFICE USE)

**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 Affairs 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.)

No	Bill No.	Purpose	Date of issue of the bills	Amount Rs.
1.				
2.				
3.				
4.				
<b>Total</b>				

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

----- **For Office use only** -----

**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-imbusement 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)