NATIONAL CENTRE FOR RADIO ASTROPHYSICS

TATA INSTITUTE OF FUNDAMENTAL RESEARCH

Pune University Campus, Ganeshkhind, Pune-411 007.

Form to be filled in by the Doctor

Certificate granted to Shri ______________________________

Employee in TIFR Pune / Narayangaon / Retd. TIFR / DAE / BARC / DOS

CERTIFICATE AND MEDICAL BILL

Certified ______________________________ was treated during the

Period from ______________ to ______________ for (name of the illness) ______________

______________ and the clinical findings are ______________

(injury etc.) ______________

My bill which has been paid is as follows :

		Bill No.	Bill Date	Amount Rs.
1	Consultation (Includes professional service charges) a) At the Clinic	______	______	
		______	______	
		______	______	
	b) At the home of the Patient (Visit)	______	______	
		______	______	
		______	______	

2 Name and quantity of the medicines / tablets powder / mixtures dispensed by the Doctor (please write clearly)

		Rs.
i		Rs.
ii		Rs.
iii		Rs.

3. Details of injection (Please write clearly)

	Name	No. of injections	Cost of injection	Pricking Charges	
i	______	______	______	______	Rs.
ii	______	______	______	______	Rs.
iii	______	______	______	______	Rs.

4 Dressing / surturing charges Rs.

5 Other charges if any Rs.

Total Rs. ______

Certified that no tonics, food / toiletry items has been prescribed [+]

1 Full name of Doctor :
2 Detailed Qualification :
3 Registration No. :
4 Place of Registration :
5 Systems of medicine used :

[+] if tonics, food or toiletry items are prescribed please give reasons thereof.

Doctor's Signature for the Bill with Rubber Stamp

Date

Employee's Name :

Designation & Section :

Basic Pay :

Patients relationship to the Employee :

CHSS No. :

Please reimburse me the following total amount being the medical expenses incurred by me for myself / my beneficiary

i	Doctors Bill			
ii	Cash Bill No. ______________		Dt. ______________	Rs.
iii	Cash Bill No. ______________		Dt. ______________	Rs.
iv	Cash Bill No. ______________		Dt. ______________	Rs.
v	Cash Bill No. ______________		Dt. ______________	Rs.
vi	Cash Bill No. ______________		Dt. ______________	Rs.
vii	Number of X-rays taken charges for each X-ray			Rs.
viii	No. of pathology tests charges for each test			Rs.

Total Rs.

[Signature of the employee]

I. D. CODE

Date :

Note : Prescription/s from the Doctor and Cash Memo/s must be attached to the bill.