APPLICATION FORM FOR MEDICAL ADVANCE

1. Name and Designation of the Government Servant:
2. Present Pay as defined in FR-9 (21):
3. Name of the patient and relationship with employee:
4. Nature of illness:
5. Amount of advance required:
6. Whether any advance for the same purpose was taken previously:
7. Whether Permanent / QP
8. Office to which attached:
9. Whether security is furnished, in the case of temporary:

Dated: Signature of the Applicant

Certified that the patient Shri / Smt _____
wife / son / daughter of Shri _____
employed in the office of _____
is being treated as an Indoor / Outdoor patient, is suffering from _____
_____. The probable duration of stay of the patient in the Hospital will be _____ days and anticipated cost of Rs. _____ under CS (MA) Rules as amended from time to time.

Certified that the patient has recognizable chance to recovery is treated otherwise than a patient in the recognized TB Institution.

Countersigned
Signature of the Suptdt./
Incharge of the hospital
with Seal.

Signature of A.M.A.