ESSENTIALITY CERTIFICATE
CERTIFICATE 'A'

Under Central Service (Medical Attendance) Rules.

(To be completed in the case of patients who are not admitted to hospital for treatment)

Photo to be attested by the Hospital Authority

Certificate granted to Mrs./Mrs./Miss.....

father/mother/wife/son/daughter of Mr. .....

employed in the Central Board of Secondary Education,.....

.....

I, Dr. ..... hereby certify:-

(a) that I charges and received Rs. .....for .....
consultation on .....&.....(dates to be given) at my consulting room
the residence of the patient;

(b) that I charged and received Rs.....for administering .....
intravenous/intra-muscular/subcutaneous injection on ..... (dates to
given) at.....
my consulting room/the residence of the patient;

(c) that the injection administered were not/were for immunising or prophylactic purposes;

(d) that the patient has been under treatment at .....
hospital/my consulting room and that the under mentioned medicines prescribed by me in
connection were essential for the recovery/prevention of serious deterioration in the condi
of the patient. The medicines are not stocked in the .....
(name of hospital) for supply to private patients and do not include proprietary preparati
for which cheaper substances of equal therapeutic value are available nor preparations which
primarily foods, toilets or disinfectants.

Names of medicines	Price (in Rs.)
1.	.....
2.	.....
3.	.....
4.	.....

(e) that the patient is/was suffering from .....
and is /was under my treatment from .....to .....;

(f) that the patient is/was not given pre-natal or post-natal treatment ;

(g) that the X-ray, laboratory test etc., for which an expenditure of Rs. ..... was incurred was necessary and were undertaken on my advice at .....
(name of the hospital or laboratory);

(h) that I referred the patient to Dr. .....for Specialist consultation and that the necessary approval of the.....
(name of the Chief Administrative Officer of the State) as required under the rules was obtained;

(i) that the patient did not require/required hospitalization.

Signature of AMA/Designation of the Medical Officer and Hospital (Dispensary to which attached)

Dated: / /20

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Checklist Form

(To be filled by the claimant)

1. Full name of the card holder (Block Letters) :
2. Health Card No. /Identity Card No :
3. Pay in Pay Band/Grade Pay /Entitlement for Ward :
4. Full Address. :
5. Telephone No./ Mobile No. :
6. Email Address, if any :
7. Name of the bank.....Branch.....
   SB A/c Branch MICR code..... Tel No. of Bank branch.....
8. Name of the patient & relationship With the card Holder :
9. Whether Serving employee or Pensioner :
10. Basic pay/ Basic pension & Last Pay Drawn :
11. Name of the hospital with address:
    (A) OPD Treatment and Investigations :
    (B) Indoor Treatment :
12. Date of admission..... Date of Discharge.....(In case of indoor Treatment only)
13. Total amount claimed
    (A) OPD Treatment (Admissible, If any) :
    (B) Indoor Treatment
14. Details of Permission (if any) :
15. Details of medical advance if any :

Declaration

I herby declare that the statements made in the application are true to the best of my knowledge and belief and the person for whom medical expenses were incurred is wholly dependent on me. I agree for the reimbursement as is admissible under the rules.

Dated: Signature of Applicant

Note: Misuse of Medical facilities is a criminal offence. Suitable action including cancellation of CBSE Health card shall be taken in case of willful suppression of facts or submission of false statements. Suitable disciplinary action shall be taken in case of serving employees.

Information

(A) Kindly write correct postal address in block letters.

(B) Obtain break up of investigations from the hospital (details and rates of individual tests and the exact number of sugar test, X-ray films, etc.) for assessment of admissibility of claimed amount on various procedures.

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