ANNEXURE – 'G'

Application for Grant of Medical Assistance for Major Diseases and Chronic Cases involving Major Operation.

To
The Secretary,
South Central Railway,
HQrs. / Divisional / Workshop SBF Committee,

TELEPHONE NUMBER
Railway :
Mobile :

1	Name of the employee in full (in Block letters)							
1(a)	Son of / Wife of (In case of female employee)							
2	Date of Appointment				Bill Unit Number			
3	Community (Tick Mark)	SC	ST	OBC	Muslim	Christian	UR	
4	Designation				Office/Station			
5	Department/Division				P. F. Number			
6	Pay in Pay Band				Running Allowance			
7	Grade Pay Substantive				Grade Pay Officiating / MACP			
8.	For whom the assistance is applied for							
9.	Name of the dependent & Relationship, If the assistance is for dependent							

Date: Signature of the employee.

Memo No. Office
Date: Station:
Forwarded, it is certified that the particulars given above are correct.

Controlling Officer.
(Designation Stamp)

Memo No. Date:
Office:_____
Station:_____

Recommended. Certified that the employee/dependent family member named has undergone major operation for on and is suffering from which is major disease/chronic case. She / He is/was under treatment from . to

(Strike off whichever is not applicable)

Divisional Medical Officer,
(Designation Stamp to be affixed)

PROFORMA 'I'

Application for grant of financial assistance from SBF for the children of Railway employees attending Schools for Deaf, Dumb, Blind and Mentally retarded.

To
The Secretary,
South Central Railway,
HQrs. / Divisional / Workshop SBF Committee,

TELEPHONE NUMBER
Railway :
Mobile :

1	Name of the employee in full (in Block letters)							
1(a)	Son of / Wife of (In case of female employee)							
2	Date of Appointment				Bill Unit Number			
3	Community (Tick Mark)	SC	ST	OBC	Muslim	Christian	UR	
4	Designation			Office/Station				
5	Department/Division			P. F. Number				
6	Pay in Pay Band			Running Allowance				
7	Grade Pay Substantive			Grade Pay Officiating / MACP				

8	Name of the Deaf, Dumb, Blind or mentally retarded child	
9.	Relationship	
10	Date of Birth & Aged of child	
11	Name of the School for Deaf, Dumb, Blind or Mentally retarded and place where the student is studying and residing in without fail.	
12	a)Amount of tuition fees paid per month	
	d) Amount of Transport charges paid per month.	
	c) Amount of residential fees paid per month.	
13	Grant of SBF received upto	
14.	Amount now claimed:	
A	Period of claim (From – To)	
B	Tuition fees	
C	Residential fees	
D	Conveyance charges incurred	
15.	Whether Vouchers/stamped receipts enclosed.	
16.	Whether the students is in receipt of any financial aid from any other source for this purpose, if so, full particulars	

The particulars mentioned above are true and the amounts received in this respect will be refunded, if the same are found incorrect. I also declare that the child for whom the FA is sought from SBF is not in receipt of the Children Education Allowance (Re-imbursement of Tuition Fee).

Date Signature of the applicant

Certified that the particulars furnished against columns 6 to 11 are correct and that the child (name)……..is a bonafide student of this Institution studying in ……class. The duration of his/her course of studies extends upto _____. He/She is not in receipt of any scholarship/Stipend/bursary from any other source. His/her conduct and progress is satisfactory.

The tuition fees/residential fees referred to above are recommended as these are essential for the prosecution of studies in the Institution.

Seal of the Institution Signature of the Principal

Place:_____ Name of the Institution

Date: _____

Memo No. Date: Office of the

Forwarded to DMO _____

The particulars furnished against columns 1 to 5 are correct.

Signature of the Controlling Officer
Designation

Memo No. Office:_____
Station: _____
Division: _____

Forwarded to the Secretary, Headquarters SBF Committee, CPO's Office, SC for necessary action.

The above particulars furnished by the employee are correct and the case is recommended for sanction.

Divisional Medical Officer.

PROFORMA 'J'

Application for sanction of financial assistance in favour of Physically Handicapped and School going Children of Railway Employees.

To
The Secretary,
South Central Railway,
HQrs. / Divisional / Workshop SBF Committee,

TELEPHONE NUMBER
Railway :
Mobile :

I hereby apply for financial assistance for my Physically Challenged School going son/daughter to cover the cost of transport from residence to school & back. Necessary particulars are furnished below:

1	Name of the employee in full (in Block letters)						
1(a)	Son of / Wife of (In case of female employee)						
2	Date of Appointment				Bill Unit Number		
3	Community (Tick Mark)	SC	ST	OBC	Muslim	Christian	UR
4	Designation				Office/Station		
5	Department/Division				P. F. Number		
6	Pay in Pay Band				Running Allowance		
7	Grade Pay Substantive				Grade Pay Officiating / MACP		
8	Name of the Physically Challenged student ward in whose favour the scholarship is sought for				Relationship with the employee		
9	Date of Birth of the School going Child				Class studying		
10	Name of the School in which studying at present.						
11	Nature of physical disability						
12	Financial assistance from SBF received upto						
13	Period for which Financial assistance is now claimed (From – To)						

The particulars furnished above are true and the amount received in this respect will be regunded if the same are found incorrect.

Date: Signature of the applicant.

PROFORMA 'J'

No. Date:

Certified that the particulars furnished against columns 8 TO 11 are correct and the child Master/Kumari. Is/was bonafide student of this institution studied last year in Class and at present studying in class academic year 20 . It is also certified that the student is a physically handicapped person.

Signature of the Headmaster
Name of the Institution (Stamp)

Memo No. Date Office

Forwarded to DMO ..... The particulars furnished against columns 1 to 8 are correct.

Office seal:

Signature of the Controlling Officer.
With Designation Stamp.

Memo No. Date Office

Forwarded to the Secretary, HQrs. SBF Committee, CPO's Office/SC for necessary action.

It is certified that .....son/daughter of Shri ..... is a physically handicapped person.

The nature disability.....

Divisional Medical Officer with stamp

PROFORMA '0'

The Chairman,
DSBF Committee,
Secunderabad Division,

I hereby apply for the reimbursement of the cost of Dentures .

1	Name of the employee in full (in Bloc letters)(a) DATE OF BIRTH						
	(b) S/O/ W/O (In case of female employee)						
2	Date of Appointment				Bill Unit Number		
3	Community(Tick mark)	SC	ST	OBC	Muslim	Christian	UR
4	Designation				Office/Station		
5	Department/Division				P.F Number		
6	Pay in Pay Band				Running Allowance		
7	Grade Pay Substantive				Grade pay officiating/MACP		
8	Whether the dentures have been recommended by the Railway Medical Authorities ?						
9	Receipt Number & Date (ORIGINAL RECEIPT to be enclosed)						
10	Cost incurred in the purchase						

I declare that I have not claimed reimbursement of cost of dentures earlier and the particulars furnished by me above' are true and I am liable for disciplinary action if proved untrue.

Encl:

Yours faithfully

Date:
Station: **Signature of the applicant**

Memo Office:
Date:

Forwarded to DMO/ ..... It is certified that the particulars given against 1 to 7 are correct.

Controlling Officer
(With office stamp)

Memo Office:
Date:

Forwarded

The employee requires replacement of his tooth/Dentures. The employee has got the tooth/dentures fixed and the replacement is satisfactory.

Divisional Medical officer
(Designation Stamp)

PROFORMA 'F'

Application for Maintenance Grant

To
The Secretary,
South Central Railway,
HQrs. / Divisional / Workshop SBF Committee,

TELEPHONE NUMBER
Railway :
Mobile :

Sir,

I have been sick from.....and without pay from ..... Please therefore sanction maintenance grant in my favour. Particulars required are furnished below.

Period of sickness as in patient.....

Period of sickness as out patient .....

Date: .....

Yours faithfully,

Signature of the Applicant

(to be filled in by the office where the applicant i.e. working)

1	Name of the employee in full (in Block letters)						
1(a)	Son of / Wife of (In case of female employee)						
2	Date of Appointment				Bill Unit Number		
3	Community (Tick Mark)	SC	ST	OBC	Muslim	Christian	UR
4	Designation				Office/Station		
5	Department/Division				P. F. Number		
6	Pay in Pay Band				Running Allowance		
7	Grade Pay Substantive				Grade Pay Officiating / MACP		
8	Period of Sickness				From		To
A	With Pay						
B	With Half Pay						
C	Without Pay						
9	Sick Certificate Number & Date						
10	Sick Certificate issued by (Designation of the Railway / Govt. Medical Officer						

Forwarded to DMO/……. It is certified that the particulars given above are correct. He has already been paid maintenance grant for the period from ……. to ……..vide sanction letter No. …….. dated …….

Office/station

Controlling Officer
Designation Stamp to be affixed

Memo No. Date Office/Stn

Recommended. The employee is on Sick List from _____ to _____ vide M 8 B Certificate No. _____ Dated _____

Period of Sickness as in patient: From: To:

Period of Sickness as out patient: From: To:

Nature of illness:
(Common name as can be understood by Non-Medical Staff Should be given)

Divisional Medical Officer
(Signature with Stamp)

PRFORMA 'H'

Application for Reimbursement of the Cost of Spectacles

TELEPHONE NUMBER

The Secretary,
South Central Railway,
HQrs. / Divisional / Workshop SBF Committee,

Railway :
Mobile :

I hereby apply for the reimbursement of the cost of spectacles purchased by me.

1	Name of the employee in full (in Block letters) (a) DATE OF BIRTH							
	(b) S/o / W/o (In case of female employee)							
2	Date of Appointment				Bill Unit Number			
3	Community (Tick Mark)	SC	ST	OBC	Muslim	Christian	UR	
4	Designation				Office/Station			
5	Department/Division				P. F. Number			
6	Pay in Pay Band				Running Allowance			
7	Grade Pay Substantive				Grade Pay Officiating / MACP			
13.	Whether applied previously, if so, when & what is the result							
14.	Receipt Number & Date (ORIGINAL RECEIPT to be enclosed)							
15	Cost incurred in the purchase							

I declare that I have not claimed reimbursement of cost of spectacles during the last 02 / 03 Financial Years. The particulars furnished by me above are true and I am liable for disciplinary action if proved untrue.

Encl:

Yours faithfully

Date:
Station:

Signature of the Applicant

Memo

Office:
Date:

Forwarded to DMO/…….. It is certified that the particulars given against 1 to 12 are correct.

Controlling Officer.
(with Office Stamp)

Memo No.

Office
Date:

Forwarded

The spectacles/change of spectacles are necessary for proper vision.

This employee is required to keep a pair of spectacles on duty

(Strike off whichever is not applicable)

Divisional Medical Officer.
(Designation Stamp)

PROFORMA 'M'

APPLICATION FOR GRANT OF CASH INCENTIVE FOR ADOPTING SMALL FAMILY NORMS AFTER ONE GIRL CHILD OR ONE MALE/TWO FEMALE CHILDREN.

To
The Secretary,
South Central Railway,
HQrs. / Divisional / Workshop SBF Committee,

TELEPHONE NUMBER
Railway :
Mobile :

I hereby apply for grant of cash incentive for adopting small family norms after one girl child or one male/two female children. Necessary particulars are furnished below:

1	Name of the employee in full (in Block letters)							
1(a)	Son of / Wife of (In case of female employee)							
1(b)	Date of Birth							
2	Date of Appointment				Bill Unit Number			
3	Community (Tick Mark)	SC	ST	OBC	Muslim	Christian	UR	
4	Designation				Office/Station			
5	Department/Division				P. F. Number			
6	Pay in Pay Band				Running Allowance			
7	Grade Pay Substantive				Grade Pay Officiating / MACP			
8	Family composition							

S. No.	Name of the dependent	Relationship	Age/DOB	Remarks
9	Number of living children (on the date operation)	MALE	FEMALE	TOTAL
10	Sterilization operation particulars.	Date of operation	Hospital/Clinic where the sterilization operation was performed	

(Note: In case the operation was done in a private Hospital, the certificate should be got countersigned by the Railway Doctor. In other cases, the copy of the certificate should attested by a Railway Officer).

Signature of the employee

DECLARATION

I hereby declare that the particulars furnished above are true complete and correct to the best of my knowledge and belief and that no fact has been concealed to derive the incentive from SBF. I also declare that the above incentive has not been claimed by my spouse (in case the spouse of the employee is also a Railway employee) / my spouse is not employed on Railways.

I fully understand that should the information provided by me is found to be incorrect at a later date, the amount granted to me is fully recoverable from my salary and I shall not take legal recourse to avoid such recovery. I am also aware that I am liable to be taken up under D&A Rules in case the information provided by me is found to be false/incorrect.

Place:
Date: Signature of the employee

We, the co-employees of
Shri……
Design……Station…… Hereby certify that the information furnished by Shri …… Is true complete and correct to the best of our knowledge. We also certify that the declaration has been signed by Shri …… in our present.

S.No.	Name	Designation	Office/Stn.	Signature

No. Office

Station

Date:

Forwarded to Chairman/HQrs. SBF Committee & CPO/SC for necessary action. The particulars furnished by the employee have been verified with the Service Register / Pass Declaration of the employee and found to be IN ORDER.

Signature
Design. & Stn.
(with office seal)