# SML ISUZU LIMITED

Mobile No: - _____

## MEDICAL REIMBURSEMENT FORM

Employees' Name : _____

E. No. : _____

Department : _____

Name of the Patient : _____

Relationship of the Claimant with the patient : Wife/Son/Daughter_____

Name of the Doctor : _____

Date of admission : _____

Date of Discharge : _____

Particulars of Medical Expense : Medical Test/Accident while on duty/ hospitalisation.

| No. & Date of Cash Memo | Name of Medicine/Test etc. | Amount | |
|---|---|---|---|
| | | Rs. | Ps. |
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| | | | |
| | | | |
| | | | |
| Amount claimed | | | |

Addition/deduction, if any : _____

Net Amount payable : _____

Passed for Rs. (in words) : _____

_____

I. Certified that my wife/Son/Daughter is wholly dependent on me and he/she has no source of his/her income. He/she is residing with me.

II. Certified that my wife/husband is employed_____ Office under Punjab/Central Government and he/she does not claim reimbursement of these charges.

Remark, if any_____

Date: _____ Signature of Claimant

_____

**FOR OFFICE USE ONLY**

Encls: _____

**(AUTHORISED SIGNATORY)**