Form No.3

DECLARATION FORM
(for Medical Facilities)

I, ______________________________(Emp. Code No. & Designation)______________________________ hereby declare that following are the members of my family who are wholly dependent upon me:

S. No.	Full Name	Relationship	Date of Birth	Age	Income if any
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

The particulars of dependent members of family as given above are correct. If any statement is found to be untrue I shall be liable for disciplinary action.

I hereby undertake to keep the above particulars up-to-date by notifying to the Head of Office any addition or alteration.

Date:________________ **Signature of Employee**

ACCEPTED

Signature of CFAO

Date:_____________

Important:

(i) ***In case Husband/Wife is employed in some other organization a Certificate from his / her employer to the effect that no medical facility is available to him/her and that no such concession if admissible will be availed hereafter.***

(ii) ***For purpose of medical attendance and treatment reimbursement of medical expenses incurred by the staff on their families only such parents would be regarded as wholly/mainly dependents on the staff members who normally reside with the staff member concerned and whose total monthly income does not exceed Rs. 9,000 plus the amount of Dearness Relief admissible on Rs. 9,000 on the date of consideration of the claim.***