**DESHBANDHU COLLEGE**

PASTE COLOURED GROUP PHOTOGRAPH OF DEPENDENT FAMILY MEMBERS

SIZE: 5X4 CMS

**(UNIVERSITY OF DELHI)**

**KALKAJI, NEW DELHI - 110019**

**APPLICATION FORM FOR MEDICAL CARD FOR MEDICAL TREATMENT IN DU APPROVED HOSPITAL**

**(FORM SHOULD BE FILLED IN CAPITAL LETTERS ONLY)**

NAME OF THE EMPLOYEE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DESIGNATION \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DEPARTMENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PAY MATRIX \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROSS PAY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF APPOINTMENT ON PERMANENT BASIS \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ DATE OF RETIREMENT \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

FATHER’S/SPOUSE NAME : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If married, the place where spouse is employed (A joint declaration duly signed by spouse employer be submitted at the beginning of each year)

RESIDENTIAL ADDRESS (As in Service Book) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MOBILE NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CONTACT NUMBER IN EMERGENCY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WUS HEALTH CENTRE MEMBERSHIP NO (In case of health centre member)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DETAILS OF DEPENDENT FAMILY MEMBERS AS PER MEDICAL ATTENDANCE RULES

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| S.NO. | NAME | RELATION | DATE OF BIRTH | WHETHER EMPLOYED | OCCUPATION/ INCOME | REMARKS |
| 1 |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |

Instructions: For availing medical facility under Direct Payment the beneficiary must carry the following:

1. Identity Card b) Medical Card (as issued by the college)

DATE : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE OF EMPLOYEE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOTE : MISUSE OF MEDICAL CARD UNDER DIRECT PAYMENT FACILITY IS A CRIMINAL OFFENCE. SUITABLE ACTION INCLUDING CANCELLATION OF MEDICAL CARD SHALL BE TAKEN IN CASE OF SUBMISSION OF FALSE INFORMATION/STATEMENTS.