

**APPLICATION FORM FOR PERMISSION FOR DOMICILIARY TREATMENT OF MINOR DISEASES LIKE
HERNIA, APPENDECTOMY ULCER, GYNECOLOGICAL DISEASES AND PROSTATE DISEASES ETC.****To****The Welfare Commissioner
Labour Welfare Organisation
Bhubaneswar****Sir,**

I hereby apply for financial assistance for undergoing domiciliary treatment of minor diseases like diseases in (Name of the hospital where the treatment has been recommended by the Medical Officer, Labour Welfare Organisation). In this connection, I submit my particulars as under :-

1. Name of the Applicant in Full
(In Block letters)
2. Name and address in full of the contractor/Agent/Cine producer owner of the industry
3. The date of his/her employment and total continuous service.
4. Designation or the nature of his/her employment.
5. His/her monthly salary/wages (excluding bonus)
6. (a) Identity Card No. in case of Beedi & Cine Workers

(b) "B" Register No. in case of Mine Worker.

Signature of Mine/Beedi worker/Cine worker**Name :****Place :****Date :**

**CERTIFICATE BY THE MINE MANAGER/OWNER AND IN CASE OF BEEDI WORKER BY
OWNER OF ESTABLISHMENT/CONTRACTOR/AGENT**

It is certified that Shri/Smt./Kum
is employed in this mine/beedi Establishment/Cine industry by me as.....
continuously with effect from and information
furnished by him/her as above at pre page is correct.

Signature :
Designation:
**Name and Address of the Mine/Beedi/Cine
Management/Contractor/Cine Producer**
Date :
**Seal of the Mine/Beedi/Cine
Establishment**

Counter signed by the Owner/Manager of the Beedi Establishment if the worker is working under Contractor / Agent.

OWNER/MANAGER
Name :
Designation :
Address :
Date :

CERTIFICATE OF THE MEDICAL OFFICER OF THE LWO

Certificate that I have carefully examined Shri/Smt./Kumari
on Dt. and found him/her suffering from
diseases. In my opinion, his/her admission in the
hospital which is recognized by the Govt. of is absolutely necessary for

His/her Identity Card No. is
"B" Register No. is

Signature :
Name :
Designation :
Name of the Dispensary/Hospital
Dated

N.B. : Please mention the generic name along with the medical terminology for the disease.

**APPLICATION FOR REIMBURSEMENT OF FINANCIAL ASSISTANCE FOR DOMICILIARY
TREATMENT OF MINOR DISEASES LIKE HERNIA, APPENDECTOMY ULCER,
GYANECOLOGICAL DISEASES AND PROSTATE DISEASE**

To,
The Welfare Commissioner,
Labour Welfare Organisation,

Sir,

I hereby apply financial benefits under the scheme for financial assistance to mine/beedi/cine workers for
..... (mention the name of the disease). I have undergone treatment for at
..... (mention the name of the hospital where the treatment has been
taken) I furnish my particulars as under :-

1. Name of the Applicant in full :
2. Identity Card No. :
3. Date of Birth :
4. Full postal/residential address of the applicant :
5. Full address of the hospital where the applicant has undergone treatment. :
6. The reference No. and date of the letter from Welfare Commissioner permitting him/her to undergo treatment in the above hospital :
7. Amount actually incurred by the Applicant for treatment (Furnish the details with supporting bills etc. each bill to be countersigned by the hospital authorities with seal and full signature) :
 - (a) Hospital charges including diet etc : Rs.
 - (b) Expenses for pre and post operation : Rs.
 - (c) Pathological Test : Rs.

Total Rs. _____

I hereby declare that the particulars furnished above are correct. If any of the particulars are found to be incorrect, I realize that I will be liable action for suitable action apart from refund or financial assistance, if any received by me.

Place :
Date :

Signature of Mine/Beedi worker / Cine worker
Name :

CERTIFICATE BY THE MANAGEMENT

It is certified that Shri/Smt/Kum
is employed in this Mine/Beedi/Cine Establishment by me as from
till date (mention designation and that his/her wage is p.m.

Signature
Designation
Name & address of the
Beedi/ Mine management
Date

CERTIFICATE OF THE TREATING PHYSICIAN OF THE HOSPITAL (REFERRAL)

Certified that Shri/Smt/Kum who
is employed as in the Mine/Beedi establishment / film industry of
producer of M/S has undergone treatment for
..... in this hospital.

He/she was admitted in the hospital for the said purpose from to
and was discharged on He/She needs rest for
day w.e.f.

Date :

Signature of the Treating Doctor

Name :

Address :

Place :

Counter signature of the superintendent of the Hospital
incase the patient is a indoor patient.

Date :

Signature with seal

Name

Address :

Place :