FORM "A"

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.....

continously 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.

FORM "B"

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 :