

दूसरी अनुसूची
THE SECOND SCHEDULE

[नियम 3 (एच) देखें]/[See Rule 3 (h)]

फार्म 1/ FORM 1

(नियम 14 देखें)/(See Rule 14)

अवकाश अथवा अवकाश बढ़ाने हेतु आवेदन
APPLICATION FOR LEAVE OR FOR EXTENSION OF LEAVE

1. प्रार्थी का नाम
Name of applicant
2. पद
Post held
3. विभाग, कार्यालय और अनुभाग
Department, Office and Section
4. वेतन
Pay
5. वर्तमान पद पर मिलने वाला मकान किराया और अन्य
प्रतिकर भत्ते
House rent and other compensatory allowances
drawn in the present post
6. मांगे गए अवकाश की किस्म, अवधि और उसके शुरू होने
की तारीख
Nature and period of leave applied for and date
from which required
7. रविवार और अवकाश के दिन, यदि कोई हों, जिन्हें अवकाश
से पहले/बाद में जोड़ना चाहते हैं।
Sundays and holidays, if any, proposed to be prefixed/
suffixed to leave
8. अवकाश का कारण
Grounds on which leave is applied for
9. पिछले अवकाश से लौटने की तारीख और उस अवकाश की
किस्म और अवधि
Date of return from last leave, and the nature and
period of that leave
10. मेरा विचार आगामी अवकाश मेंब्लाक
वर्षों के लिए अवकाश यात्रा रियायत लेने का है/नहीं है।
I propose/do not propose to avail myself of leave
travel concession for the block years.....
during the ensuing leave.
11. अवकाश के दौरान पता
Address during leave period :

तारीख

Date.....

प्रार्थी के हस्ताक्षर
Signature of Applicant

12. नियंत्रण अधिकारी की टिप्पणी और/या सिफारिश
Remarks and/or recommendation of the Controlling
Officer

तारीख

Date.....

हस्ताक्षर/Signature.....

पदनाम/Designation.....

अवकाश की अनुमत्यता के बारे में प्रमाण-पत्र
CERTIFICATE REGARDING ADMISSIBILITY OF LEAVE

13. प्रमाणित किया जाता है कि.....से.....तक दिन के लिए केन्द्रीय सिविल सेवा (अवकाश) नियमावली, 1972 के नियम.....के अधीन.....(अवकाश की किस्म) अनुमत्य है।

Certified that.....(Nature of leave) for.....
(Period) from.....to.....is admissible under Rule.....
of the Central Civil Services (Leave) Rules, 1972.

तारीख
Date.....

हस्ताक्षर/Signature.....

पदनाम/Designation.....

*14. अवकाश स्वीकृति हेतु सक्षम अधिकारी के आदेश।
Orders of the authority competent to grant leave.

तारीख
Date.....

हस्ताक्षर/Signature.....

पदनाम/Designation.....

*यदि प्रार्थी को कोई प्रतिकर भत्ता मिलता है तो मंजूरी करने वाले अधिकारी को यह लिखना चाहिए कि अवकाश पूरा होने पर प्रार्थी को उसी पद पर या किसी ऐसे पद पर लौटने की आशा है या नहीं जहां इसी प्रकार का भत्ता मिलता हो।

*If the applicant is drawing any compensatory allowance, it should also be indicated in the orders on the expiry of leave, the Government servant is likely to return to the same post or to another post carrying similar allowance.

दौरे के लिए यात्रा भत्ता बिल TRAVELLING ALLOWANCE BILL FOR TOUR

टिप्पण — इस बिल को दो प्रतियों में, एक संदाय के लिए और दूसरी कार्यालय प्रति के रूप में, तैयार किया जाना चाहिए।
Note --- This bill should be prepared in duplicate, one for payment and the other as office copy.

भाग - क (सरकारी सेवक द्वारा भरा जाना चाहिए)
PART - A (To be filled up by Government Servant)

1. नाम
Name.....
2. पदनाम
Designation.....
3. वेतन
Pay.....
4. मुख्यालय
Headquarters.....
5. की गई यात्रा/यात्राओं के ब्यौरे और प्रयोजन :—
Details and purpose of journey(s) performed

प्रस्थान/Departure		आगमन/Arrival		यात्रा की रीति और स्थान सुविधा का वर्ग Mode of travel and class of accommodation	संदत यात्री भाड़ा Fare Paid		सड़क मील भत्ता के लिए दूरी कि.मी. में Distance in Kms. for road mileage	विश्राम की अवधि Duration of halt		यात्रा का प्रयोजन Purpose of journey
तारीख और समय Date and Time	से From	तारीख और समय Date and Time	तक To		रु. Rs.	पै. P.		दिन Days	घंटे Hours	
1	2	3	4	5	6	7	8	9		

6. यात्रा की रीति :—
Mode of journey :—

(i) वायुयान/Air

(क) कार्यालय द्वारा व्यवस्थाकृत विनिमय वाउचर
(a) Exchange voucher arranged by officer हां/नहीं
Yes/No

(ख)द्वारा व्यवस्थाकृत
टिकट/विनिमय वाउचर.....

(b) Ticket/Exchange voucher arranged by.....

(ii) रेल/Rail

(क) क्या यात्रा मेल/एक्सप्रेस/सामान्य गाड़ी से की गई ?
(a) Whether travelled by mail/express/ordinary train ?

(ख) क्या वापसी टिकट उपलब्ध था ?
(b) Whether return tickets available ? हां/नहीं
Yes/No

(ग) यदि उपलब्ध था तो क्या वापसी टिकट खरीदा गया ?
यदि नहीं तो कारण बताएं।

(c) Is available, whether return tickets purchased ?
If not, state reasons.

10. उन यात्रा/यात्राओं की विशिष्टियां, जिनके लिए सरकारी सेवक ने उस वर्ग से जिसका वह हकदार है, उच्चतर वर्ग की स्थान सुविधा का उपयोग किया है :—
Particulars of journey(s) for which higher class of accommodation than the one to which the Govt. servant is entitled was used :—

तारीख Date	स्थानों का नाम Name of Places		वाहन का प्रकार जिसका उपयोग किया गया है Mode of conveyance used	वह वर्ग जिसका हकदार है Class to which entitled	वह वर्ग जिसमें यात्रा की है Class by which travelled	उस वर्ग का यात्री भाड़ा जिसका हकदार है Fare of the entitled class	
	से From	तक To				रु. Rs.	पै. P.
1	2	3	4	5	6	7	

यदि उच्चतर वर्ग की स्थान सुविधा में की गई है यात्रा/यात्राएं सक्षम प्राधिकारी के अनुमोदन से की गई है तो मंजूरी की सं. और तारीख उद्धृत करें।
If the journey(s) by higher class of accommodation had been performed with the approval of the competent authority, No. and date of the sanction may be quoted.

11. रेल से जुड़े स्थानों के बीच सड़क से की गई यात्रा/यात्राओं के ब्यौरे :—
Details of journey(s) performed by road between places connected by rail :—

तारीख Date	स्थानों का नाम Name of Places		संदत भाड़ा Fair paid
	से From	तक To	
1	2	3	4 रु./Rs.

12. लिए गए यात्रा भत्ता अग्रिम की रकम, यदि कोई हो।
Amount of T. A. advance, if any, drawn.

प्रमाणित किया जाता है कि उपरोक्त जानकारी मैंने सर्वोत्तम ज्ञान और विश्वास के अनुसार सत्य है।
Certified that the information given above is true to the best of my knowledge and belief.

सरकारी सेवक के हस्ताक्षर
Signature of the Govt. Servant

तारीख

Date.....

भाग — ख (बिल अनुभाग में भरा जाना है)
PART — B (To be filled in the Bill Section)

1. यात्रा भत्ते मद्दे शुद्ध हकदारी..... रु० बनी है जिसके ब्यौरे नीचे दिए गए हैं :—
The net entitlement of account of travelling allowance works out to Rs..... as detailed below :—

- (क) रेल/वायुयान/बस/स्टीमर यात्री भाड़ा रु०.....
(a) Railways/Air/Bus/Steamer fare : — Rs.....
- (ख)कि०मी० के लिए सड़क मील भत्ता..... पैसे प्रति कि०मी० की दर से
..... रु०
(b) Road mileage for.....Kms. @ Rs..... P/Km.
- (ग) दैनिक भत्ता
(c) Daily allowance
- (i)दिन/day @ Rs.....रु० प्रति दिन की दर से/Per day.
(ii)दिन/day @ Rs.....रु० प्रति दिन की दर से/Per day.
(iii)दिन/day @ Rs.....रु० प्रति दिन की दर से/Per day.
- (घ) वास्तविक व्यय रु०/Rs.....
(d) Actual expenses रु०/Rs.....
रु०/Rs.....
रु०/Rs.....

कुल राशि
Gross amount

- (ङ) वाउचर सं०..... तारीख..... के अनुसार लिए गए यात्रा भत्ता अग्रिम की रकम को यदि कोई हो, घटा दें।
(e) Less amount of T. A. advance, if any, drawn vide Voucher No.....date.....रु०/Rs.....

शुद्ध रकम रु०.....
Net amount Rs.....

1. व्यय.....में विकलनीय है।
The Expenditure's debitible to.....

बिल लिपिक के आद्यक्षर
Initials of Bill Clerk

आदाम और संवितरक अधिकारी के हस्ताक्षर
Signature of D D O

प्रति हस्ताक्षरित
Countersigned

नियंत्रक अधिकारी के हस्ताक्षर
Signature of Controlling Officer

सामान्य भविष्य निधि से आहरण के लिए आवेदन पत्र/प्रस्ताव प्रपत्र

1. अभिदाता का नाम/पदनाम/ लेखा संख्या :-
2. वेतन :-
3. सेवा ग्रहण/निवृत्ति की तिथि :-
4. आवेदन की तिथि पर अंशदाता के लेखा में शेष राशि का व्यौरा
(क) वर्ष.....की विवरणी के अनुसार अंतशेष.....
(ख)से तक मासिक अंशदानों का लेखा.....
(ग) उपरोक्त (क) के अंतशेष के पश्चात खाते में
वापिस की गई राशि.....
(घ)से तक लिया गया अग्रिम.....
(ङ) आवेदन की तिथि पर खाते में निवल जमा शेष.....
5. वांछित आहरण राशि और उसका उद्देश्य
6. नियम जिसके अंतर्गत आहरण मांगा गया है.....
7. क्या इसी उद्देश्य के लिए पहले भी आहरण किया गया था?
अगर ऐसा था तो वर्ष और राशि बताएं

प्रार्थी के हस्ताक्षर

कार्यालय प्रयोग के लिए

श्री/श्रीमती _____ ने अपने सामान्य भविष्य निधि में से रु
_____/-(केवल _____रूपए) की आहरण राशि
निकालने के लिए आवेदन किया है। कर्मचारी का कार्यालय में कार्यकाल 15 वर्ष से अधिक है अतः आहरण
के लिए आवेदन कर सकता है। आवेदन में मांगी गई राशि तथा उसका उद्देश्य सामान्य भविष्य निधि के
नियम _____ तथा _____ के अधीन देय है।

उप महालेखाकार(लेखा एवं हक) कृपया श्री/श्रीमती _____ के पक्ष में
में उसके सामान्य भविष्य निधि खाते में से रु._____/-(केवल _____रूपए)
की आहरण राशि निकालने को स्वीकृति प्रदान करने पर विचार करें।

प्रस्तुत किया जाता है

सहायक लेखा अधिकारी(प्रशासन-1)

C.P.F. withdrawal

STATEMENT OF IMMOVABLE PROPERTY AS ON 31/12/2017

1. Name of officer (in full) and services
in which the officer belongs :- _____.
2. Present post held :- _____.
3. Present Pay :- _____.

Name of District, Sub-Division & village in which property is situated	Name & Details of Property		Present Value (approximately)	If not in own name state in whose name held and his/her relationship to the govt. Servant	How acquired whether by purchase, lease**, mortgage, Inheritance, gift or otherwise, with date of acquisition and name with details of person/persons from whom acquired	Annual income from the property	Remarks
	Housing & other buildings	Lands					

Signature: _____

Date: _____

CENTRAL GOVERNMENT HEALTH SCHEME

MEDICAL REIMBURSEMENT CLAIM FORM

(To be filled up by the Principal Card holder in **BLOCK LETTERS**)

1. (a) Name of the Principal CGHS Card Holder :
(b) CGHS Ben ID No. :
(c) Employee Code No. :
(d) Ward Entitlement – Pvt./Semi-Pvt./General :
(e) Full Address :

(f) Mobile telephone No. and e-mail address, if any :
2. (a) Patient's Name :
(b) Patient's CGHS Ben ID No. :
(c) Relationship with the Principal CGHS card holder :
3. Name & address of the hospital / diagnostic center /
imaging center where treatment is taken or tests done:
4. Whether the hospital/diagnostic/imaging center is
empanelled under CGHS : Yes/No
5. Treatment for which reimbursement claimed
(a) OPD Treatment /Test & investigations :
(b) Indoor Treatment :
6. Whether treatment was taken in emergency : Yes/No
7. Whether prior permission was taken for the treatment : Yes/No
8. Whether subscribing to any health/medical insurance : Yes/No
scheme, If yes, amount claimed/received
9. Details of Medical Advance taken, if any :
10. **Total amount claimed**
(a) OPD Treatment :
(b) Indoor Treatment :
(c) Tests/Investigation :
11. Name of the Bank : SB A/c No.:
Branch MICR Code: IFSC Code.....

DECLARATION

I hereby declare that the statements made in the application are true to the best of my knowledge and belief and the person for whom medical expenses were incurred is wholly dependent on me. I am a CGHS beneficiary and the CGHS card was valid at the time of treatment. I agree for the reimbursement as is admissible under the rules.

Date :

Place:

Signature of the Principal CGHS card holder

Documents to be attached

1. Photo copy of the CGHS card of the employee along with the patient's CGHS Card.
2. Copy of permission letter, if any.
3. Emergency certificate (original), in case of emergency.
4. Copy of the discharge summary.
5. Ambulance Certificate (original), if any.
6. Original bills /cash memo / vouchers etc. for the reimbursement amount claimed.

IMPORTANT

Kindly ensure to provide the following information / documents, wherever applicable:

- a) Obtain Break up of Investigations from the hospital/diagnostic center/imaging center (details and rates of individual tests and the exact number of tests, X-ray films, etc.) as the reimbursable amount is calculated as per approved CGHS rates per test.
- b) In case of loss of original papers, Affidavits as per Annexure I to be submitted. All photocopies of the bills to be attested by the treating doctor/specialist.
- c) In case of death of the card holder, Affidavit as per Annexure II to be filled and attached to claim reimbursement,
- c) In case of implants, Invoice No. along with sticker with serial number of the implant to be attached.
- d) In case of Coronary Stents, outer pouch of stents is to be enclosed.
- e) In case of replacement of pacemaker / ICD etc., copy of the warranty certificate of earlier pacemaker/ICD may be enclosed.

Note: *Misuse of CGHS facilities is a criminal offence. Penal action including cancellation of CGHS card may be taken in case of willful suppression of facts or submission of false statements. Suitable disciplinary action shall be taken in case of serving employees.*

Annexure –I

Draft for Affidavit for Duplicate Claim Papers/bills on stamp Paper

I, son / wife / daughter of.....and resident of
.....have lost / misplaced the original paper or
the same are not traceable. I hereby give an undertaking that I have not received any payment
against the original bills/claim papers from any source and that if the original papers are traced, I
shall not stake claim against original bills in future and that in the event, I receive any cheque
against the original bills in future, I shall return the same to competent authority.

Deponent

Verified by Notary Public

CENTRAL GOVERNMENT HEALTH SCHEME

MEDICAL REIMBURSEMENT CLAIM FORM

(To be filled by the Principal Card holder/Claimant in BLOCK LETTERS)

1. (a) Name of the Principal CGHS Card Holder :
(b) CGHS Ben ID No. :
(c) CGHS Wellness Center to which the card is attached :
(d) Validity of CGHS Card :
(e) Ward Entitlement – Pvt./Semi-Pvt./General :
(f) Full Address :

(g) Mobile telephone No. and e-mail address, if any :
2. (a) Patient's Name :
(b) Patient's CGHS Ben ID No. :
(c) Relationship with the Principal CGHS card holder :
3. Category of pensioner beneficiary - please specify :
(Central Govt. Pensioner/Pensioner of Autonomous/Statutory body/Ex- MP/ Ex-Governor/ Former Judge of Supreme Court/ Former Judge of High Court/Freedom Fighter/Legal Heir/Others)
4. Name & address of the hospital / diagnostic center / imaging center where treatment is taken or tests done:
5. Whether the hospital/diagnostic/imaging center is empanelled under CGHS : Yes/No
6. Treatment for which reimbursement claimed :
(a) OPD/Test & investigations :
(b) Indoor Treatment :
7. Whether credit facility was availed. If not, reasons thereof (clarification may be attached) :
8. Whether treatment was taken in emergency : Yes/No
9. Whether prior permission was taken for the treatment : Yes/No
10. Whether subscribing to any health/medical insurance scheme, If yes, amount claimed/received : Yes/No
11. **Total amount claimed** :
(a) OPD Treatment :
(b) Indoor Treatment :
(c) Tests/Investigation :
12. Name of the Bank : SB A/c No.:
Branch MICR Code: IFSC Code.....

DECLARATION

I hereby declare that the statements made in the application are true to the best of my knowledge and belief and the person for whom medical expenses were incurred is wholly dependent on me. I am a CGHS beneficiary and the CGHS card was valid at the time of treatment. I agree for the reimbursement as is admissible under the rules.

Date:

Place:

Signature of the Principal CGHS card holder / Claimant

Documents to be attached

1. Photo copy of the CGHS card of the principal card holder along with the patient's CGHS Card.
2. Copy of permission letter, if any.
3. Emergency certificate (original), in case of emergency.
4. Copy of the discharge summary.
5. Ambulance Certificate (original), if any.
6. Original bills /cash memo / vouchers etc. for the reimbursement amount claimed.

IMPORTANT

Kindly ensure to provide the following information / documents, wherever applicable:

- a) Obtain Break up of Investigations from the hospital/diagnostic center/imaging center (details and rates of individual tests and the exact number of tests, X-ray films, etc.) as the reimbursable amount is calculated as per approved rates per test.
- b) In case of loss of original papers, Affidavits as per Annexure I to be submitted. All photocopies of the bills to be attested by the treating doctor/specialist.
- c) In case of death of the card holder, Affidavit as per Annexure II to be filled and attached to claim reimbursement,
- c) In case of implants, Invoice No. along with sticker with serial number of the implant to be attached.
- d) In case of Coronary Stents, outer pouch of stents is to be enclosed.
- e) In case of replacement of pacemaker / ICD etc., copy of the warranty certificate of earlier pacemaker /ICD may be enclosed.

Note: *Misuse of CGHS facilities is a criminal offence. Penal action including cancellation of CGHS card may be taken in case of willful suppression of facts or submission of false claims / statements.*

Annexure –I

Draft for Affidavit for Duplicate Claim Papers/bills on stamp Paper

I, son / wife / daughter of.....and resident of
.....have lost / misplaced the original paper or
the same are not traceable. I hereby give an undertaking that I have not received any payment
against the original bills/claim papers from any source and that if the original papers are traced, I
shall not stake claim against original bills in future and that in the event, I receive any cheque
against the original bills in future, I shall return the same to competent authority.

Deponent

Verified by Notary Public

Annexure – II

**Draft for Affidavit on Stamp Paper for claiming medical reimbursement
IN CASE OF DEATH of a CGHS Card Holder**

I,.....husband / wife / son / daughter of Late..... and resident of, hereby submit the medical reimbursement claim papers pertaining to treatment of my husband / wife / father / mother Late Shri/ Smt.....who has expired on (*copy of Death Certificate is enclosed*).

Late Shri/Smt.....has left behind the following other legal heirs, none of whom have any objection if the entire reimbursable amount is paid to me.

No Objection Certificate signed by other legal heirs on Stamp paper is enclosed.

Deponent

Attested by Notary Public

=====

Draft for No Objection Certificate on Stamp Paper.

We (i)..... S/o D/o Late Shri.....
(ii)..... S/o D/o Late Shri.....
(iii)..... S/o D/o Late Shri.....
(--)
(--)
(--)

being the legal heirs of Late Shri/Smt..... have no objection if the entire amount reimbursable pertaining to the treatment of late Shri / Smtis paid to Shri / Smt

(i) (Signature)
Name:
Address:

(ii) (Signature)
Name
Address:

(iii) (Signature)
Name:
Address

(iv).....

(v).....

(vi).....

Verified by Notary Public