DECLARATION FOR CONTINUATION OF MEDICAL FACILITIES (Format)

YEAR : ______ Medical file No.: ___________ Unit: __________

1. Name of the employee : ___________________________________
(CAPITAL LETTERS)

2. Designation: _________ 3.ICNo.:________ 4.Section:______

5. Ph.No.:_______________ 6. Address:

7. Details of children above 18 years of age/parents (or parent-in-laws)/spouses working outside DAE requiring continuation of medical facility:

Medical card No.	Name of the beneficiary	Relationship	Date of birth	Income & medical allowance/assistance

Note: Indicate income from all sources including total pension amount if any. For children, indicate course of study if any.

Date: **Signature of the employee**

(To be forwarded through Administration)

Date: **Signature**
(Seal)