**FORM OF APPLICATION FOR GRANT OF SUBSISTENCE ALLOWANCE TO DEPENDANTS OF MINE/BEEDI/CINE WORKERS UNDER THE DOMICILIARY TREATMENT OF T. B. SCHEME.**

1. Name in full of the workers

2. Name and address in full of the

mine/beedi establishment where

the worker is employed.

3. Designation or the nature of

his/her employment.

4. The date of his/her employment

and period of service at the Mine /Beedi

Establishment before contacting T.B.

5. His/her monthly salary/wages

(excluding bonus)

6. If he/she (patient) is getting

any financial assistance from

any mine management/beedi

establishment or from any source.

If so, state amount with the period.

7. Number of dependants of the

Mine/Beedi worker (patient)

(Dependants include wife/

husband, unmarried children and

step children residing with and

whollydependant on the worker)

8. Name, age, marital status and

relationship of each dependant.

9. Name and address of the

dispensary/hospital where the

worker is being treated.

10. A certificate that the patient is the

only earning member of the family

and has no other source of income

from Mine Manager/Beedi Establishment

or from District Magistrate or any gazette

officer authorized by himor by the

Headman of village Panchayat.

11. Certificate of the Manager of

Mine/Beedi Establishment/

 District Magistrate/Headman

of village.

Certified that the statement made by the applicant against items 1 to 8 have been verified and found to be correct.

Manager/Agent/Owner of

Mine/Beedi Establishment

2nd certificate of the medical authority.

Certified that the statement of the applicant against item 9 is correct. He/she is/has been receiving regular treatment from this dispensary/hospital.

Signature

Designation

Official Stamp.

**APPLICATION FORM FOR CLAIMING**

**TREATMENT**

**CHARGES BY MINE/BEEDI/CINE WORKERS**

**UNDER**

**THE DOMICILIARY TREATMENT OF T.B.**

 SCHEME

1. Name in full of the worker

2. The name and address in full of

the mine/beedi establishment

where the worker is employed.

3. Date of his/her employment and

the total continuous service in the

mine/beedi establishment.

4. Designation or the nature of his/

her employment.

5. His/her monthly salary/wages

(Excluding Bonus)

6. The Dispensary/Hospital where the

worker is undergoing Domiciliary

treatment for T.B.

Signature

Date:

 Name

ATTESTATION OF THE MANAGER/OWNER

It is certified that Shri /Smt.\_\_\_\_\_\_\_\_\_\_\_\_is employed in this mine/establishment as \_\_\_\_\_\_\_\_\_\_\_\_\_continuously for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_years months. It is certified that the statement made by the applicant against cols. 1 to 6 above have been verified and found to be correct.

Signature

Manager/Owner

Name & Address of

Date: SEAL the Establishment.

**CERTIFICATE OF THE MEDICAL OFFICER**

Shri\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_employed in\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_mine / establishment and whose signature/thumb impression is given hereunder, was examined by me on\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_and was found to be suffering from T.B. According to my opinion, he/she has to receive regular domiciliary treatment for T.B.

Date SEAL Signature

Name