**FORM OF APPLICATION FOR OBTAINING SPECTACLES FROM THE LABOUR WELFARE ORGANISTAION.**

1. Name :

2. Father‟s Name :

3. Age :

4. Sex :

5. Name of the Mine/Beedi

Establishment/Contractor /Agent

where employed at present. :

6. Name of the owner of the Mine

BeediEstt./ Contractor/ Agent. :

7. Designation. :

8. Date of appointment :

9. Mine/BeediEstt./ Contractor in

which he has worked in the past

with approximate month & year. :

10. Wages received per month :

11. Does he/she already wear the

Spectacles?:

Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of the applicant.

CERTIFICATE OF MANAGEMENT/CONTRACTOR / AGENT

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| S.No. | Name of Mine/BeediEstt./Contractor/ Agent. | B.R.No. | Period From | Period  To | Total Service. | Signature of the Manager/Contractor/ Agent in token of having certified the service period. |
|  |  |  |  |  |  |  |

12. Service rendered from time to time

It is further certified that he/she gets Rs. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (In words Rupees \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) exclusive of bonus, per month and his economic condition is so poor that he/she cannot purchase a Spectacles. He/she deserves providing of Financial Assistance for Spectacles.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Manager/Owner/Contractor Agent.

Seal of Management.

CERTIFICATE OF MEDICAL OFFICER OF THE ORGANISATION

It is certified that I have examined Shri/Kum./Smt. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ S/o, D/o of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ employed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ carefully and have come to the conclusion that he/she need corrective lenses to improve his/her vision. The case deserves further examination by an Eye Specialist. He/She is, therefore, referred to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Name of the Hospital is to be given) or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Qualified Private Eye Specialist).

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_ Designation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Seal

CERTIFICATE OF THE EYE SPECIALIST

Certified that I have examined Shri/Kum./Smt. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ S/D/W of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ aged \_\_\_\_\_\_\_\_\_ Sex \_\_\_\_\_\_\_\_\_\_\_\_\_\_ carefully and allot the vision/lenses number is under:-

Right vision Left vision

I further suggest that the patient should continue to take the following treatment for a period of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ after this he/she should attend the hospital/clinic on for re-check.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Officer / Eye Specialist

SEAL