**FORM – „A‟**

**APPLICATION FOR TREATMENT OF MINE/BEEDI/CINE WORKERS SUFFERING FROM CANCER**

1. Name in full of worker.

2. Name & Address in full of mine/beedi establishment.

3. Name of patient.

4. Age and relationship with the worker.

5. Date of his/her employment and the total continuous service.

6. Designation of the nature of his/her employment.

7. His/her monthly salary/ wages (excluding bonus).

8. The hospital where treatment is sought.

9. Whether the applicant/ dependent had undergone treatment for

Cancer previously? If so, mention the duration of the treatment.

Signature

Date : Thumb impression

(Name in Block letters)

**ATTESTATION BY THE PRODUCER/OWNER OF THE FILM INDUSTRY**

**Certified that Shri/Smt./Kum.-----------------------------------------is employed in this Industry as continuously wef----------------------------------------and information furnished by him/her above is correct to the best of my knowledge and belief.**

**Signature:**

**Designatioj with seal**

 **Seal of the Film Indurstry/owner**

**Place-------------**

**Date--------------**

**ATTESTATION BY THE MANAGER / OWNER OF THE MINE/BEEDI ESTABLISHMENT**

Certified that Shri/Smt./Kum. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is employed in this mine/beedi

establishment as \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ continuously w.e.f. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

and information furnished by him/her above is correct to the bet of m knowledge and belief.

Signature

Place: \_\_\_\_\_\_\_\_

Designation with Seal

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

 Seal of the Management

Beedi establishment.

**CERTIFICATE BY THE MEDICAL OFFICER OF THIS ORGANISATION**

Certified that Shri/Kum ………………………………………… employed in

………………………… and whose signature/thumb impression is given here

under was examined by me on ……………………………. and found to be

sufferingform cancer. According to my opinion his/her admission/treatment in a

recognized. Cancer Hospital is absolutely necessary for a period of

…………………………… months.He/She is, therefore, referred to

……..……………………………………. (Name of the Cancer Hospital to be

furnished).

OR

Certified that Shri/Smt./Kum ………………………………………………..

Wife/son/daughter/father/mother of …….…………………………………………

employed in ……………………………………. and whose

signature/thumb

impression is given here under was examined by me on

…………………………………………. and found Hospital is absolutely

necessary for a period of ………………………………… months. He/She/is,

therefore referred to ………………………………………….. (Name of the

Cancer Hospital to be furnished).

Signature

Name & Designation Date …………Seal

**CERTIFICATE OF THE MEDICAL OFFICER OF THE RECOGNISED CANCER HOSPITAL**

Certified that Shri/Smt./Kum ……………………………………………………

who is employed as …………………………………………………….. in the

mine/beedi establishment has been carefully examined and found to be

suffering from Cancer, according to my opinion his/her admission/treatment in

one of the Cancer Hospital is absolutely necessary for a period of

……………………………….. (Approximately).

Or

Certified that Shri/Smt./Kum ….…………………………………………….

wife/son/daughter/father/mother of

……………………………………………… who is employed as

………………………………………….. in the mine/beedi establishment of

…………………………………….. has been carefully examined and found to

be suffering from cancer. According to my opinion his/her admission/treatment

in one of the Cancer Hospital is absolutely necessary for a period of

………………………………… (Approx).

Signature

Date …………………

Name & Designation

Seal

**Form – “B”**

**APPLICATION FOR CLAIMING REIMBURSEMENT OF EXPENDITURE TREATMENT OF CANCER**

To,

The Welfare Commissioner,

Labour Welfare Organization,

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

Sir,

I hereby apply for reimbursement of expenditure for the treatment of

cancer, I/my wife/son/daughter/father/mother have/has undergone

treatment for cancer in …………………………………….. (Mention

name of hospital where the treatment has been taken).

1. Name of the applicant in full

(In block letters)

2. Date of birth and age

3. Full address of the applicant

4. Name of the patient

5. Age and relationship with the worker

6. Name and address of the

 Mine management/BeediEstt./ in

which he/she employed.

7. Date of continuous employed

in the Mine/Beedi Establishment

Showing the total continuous service.

8. Is the applicant‟s wife or husband employed in the Mine/Beediestablishment? Give details.

9. Full address of the hospital where

the applicant/dependent

has undergone treatment for cancer.

10. Please quote reference number date of the Welfare

 Date of welfare

Commissioner in which he/she permitted to undergo treatment in the above hospital.

11. Amount claimed as subsistence

allowance showing the duration

of the claim.

12. Amount actually incurred/claimed

by the applicant for medicines, Furnish

details with supporting vouchers/bills etc.

13. Amount actually incurred/claimed

by the applicant on diet, furnish details

with supporting bills etc.

14. Amount claimed as bus/train charges.

15. Amount claimed as D.A.

I hereby declare that the particulars furnished above are correct to the best

of my knowledge and belief. If any of the particular is found to incorrect,

I realize that I will be liable for suitable action a part form refund of

financial assistance received by me.

Place : Signature of the applicant

or thumb impression

Date : (Name in block letters) **CERTIFICATE BY THE MEDICAL OFFICER OF THE RECOGNIZED CANCER HOSPITAL**

Certified that Shri/Smt./Kum.

…………………………………………………… who is employed as

…………………………………………………… in the Mine/Beedi

Establishment of ……………………………… has undergone treatment

in this hospital as in-patient/out-patient for cancer with effect form

…………………………………

OR

Certified that Shri/Smt./Kum. …………………………………

wife/son/daughter/ father/mother of Shri/Smt./Kum.

……………………………………… who is employed as

……………………..……………………………… in the Mine/Beedi

Establishment of

……………………………………………………………… has

undergone treatment in this

…………….……………………………………………… hospital as in-

patient./ out-patient for cancer with effect from …………………… to

……………………..

Signature of the Medical

Date ……………

 Officer of the Hospital

Designation & Seal

CERTIFICATE OF THE MANAGEMENT

Certified that Shri/Smt./Kum. ……...………………………………… is employed in the

Mine/Beedi Establishment as …………………………………………… (mention

designation) and that his/her wage is …………………………. Per month.

Certified that Shri/Smt./Kum. ….……………………………………………… is working

in this Mine/Beedi Establishment/Producer/Owner since ……………….

Certified that no wage has been paid to Shri/Smt./Kum. ………………………… for the

period of his/her treatment from …………………………. To ……………………

Designation with Seal

Seal of the Mine/Beedi

Date :

 Establishment